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Informal Payments for Health Care in Hungary

Ph.D. Thesis

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ABSTRACT

There is a growing international interest in informal payment for health care – a payment that patients give, typically to medical doctors, for formally free services. The phenomenon is widespread and persistent in post-communist countries, but also reported from other countries in Africa and Asia.

This thesis focuses on informal payments in Hungary, aiming to establish their scale and the motivation for giving, issues whose understanding are crucial in assessing their policy importance.

The theoretical literature can be summarised in two contrasting hypothesis for informal payments. One is that patients pay because they want better care, which implies that payments reflect, and may sustain, defects in service delivery. This thesis elaborates a new theoretical framework that builds on this ‘fee-for-service’ hypothesis and Hirschman’s theory of ‘exit, voice, loyalty’, identifying informal payments as one manifestation of another response to a perceived decline in health services: informal/internal exit or ‘inexit’ for short. The opposing view, the ‘donation’ hypothesis, however, considers such payments as motivated by gratitude, with no adverse effect on performance of health care. Unfortunately, previously existing evidence is inconclusive regarding both the motivation and scale of informal payments.

The empirical part of this thesis addresses both issues directly, and also indirectly addresses motivation exploring any impact on equity, using a household survey, in-depth interviews with patients and doctors, secondary analysis of existing datasets, official statistics and documentary analysis.

Findings suggest that informal payment is indeed a problem in Hungary. First, although it is not a substantial source of health care financing (less than 5% of total expenditures in 2001), its importance as an incentive comes from its extent and distribution (at least 60% of the net income of family doctors and specialists) rather than its overall magnitude. Second, although survey findings did not confirm informal payment as a barrier to utilization and they supported gratitude as the most important motive, a contradiction has been found between the reasons for giving cited in the household survey and the revelation of pressures on patients to pay from in-depth interviews. Taken together, these suggest that payments generally take place in a ‘coercive’ context, so the case for the ‘donation’ hypothesis is weak.

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ACRONYMS & GLOSSARY OF TERMS

CEE	= Central and Eastern Europe
CI	= Confidence Interval
‘Coercion factor’	= Various pressures on patients to give informal payments (or on doctors to accept informal payments).
‘Coercive’ reasons of giving	= Operationalisations of motivation that are incompatible with the ‘donation’ hypothesis (e.g. expected by health workers).
‘Donation’ hypothesis/explanation	= Considers informal payments as an expression of patients’ gratitude
DRG	= Diagnosis Related Groups
EU	= European Union
‘Fee-for-service’ hypothesis/explanation	= Considers informal payments as a means to obtain (better) care
FSU	= Former Soviet Union
GDP	= Gross Domestic Product
HCSO	= Hungarian Central Statistical Office (Központi Statisztikai Hivatal, KSH)
HBS	= Household budget survey The regular household survey of the HCSO on household income and expenditures.
HIF	= Health Insurance Fund
MOH	= Ministry of Health, Social and Family Affairs
NHA	= National Health Accounts
NHIFA	= National Health Insurance Fund Administration
‘Non-coercive’ reasons of giving	= Operationalisations of motivation, which correspond the ‘donation’ hypothesis (initially we considered two such motives: ‘I was grateful’ and ‘it is customary’).
‘Non-paying’ patient/specialty	= Patients, who do not give informal payments, or specialties, where informal payment is rare, insignificant or non-existent.
‘Paying’ patient/specialty	= Patients, who give informal payments, or specialties, where informal payment is common and substantial.
PPP	= Purchasing power parity
SE	= Standard Error

"People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices."

(Adam Smith, 1776 [5; cited in 6])

"Everything depends on that whether the socialized medical doctor receives in exchange for her work, what she is entitled to on the basis of her education, social status and work related responsibility, according to the extent she is utilized. Since the socialized medical doctor usually does not get this, socialization virtually means expropriation [of medical work] below its real value...

*The reason for this does not need to be explained in more detail, so I say only that the main reason can be found in the decreased ability of our illness insurance to bear the financial burden of care, coupled with its huge power, against which the unorganised and splintered Hungarian medical profession has always proven to be weak."*¹

(Keleti, 1942 [7; cited in 8,pp.10-11])

¹ "Minden attól függ, hogy a szocializált orvos munkája ellenértékéért megkapja-e azt, amire tanultságánál, társadalmi helyzeténél, munkájával járó felelősségénél fogva az igénybevétele arányában jussa van. Minthogy rendszerint a szocializált orvos nem kapja meg ezt, a szocializálás gyakorlatilag az értéken aluli kisajátítást jelenti...

Ennek okát felesleges jobban részleteznem, ezért csak annyit mondok, hogy a legfőbb ok a betegségi biztosításunk csökkent teherviselőképességében, de annál nagyobb hatalmi erejében keresendő, mellyel szemben a megszervezhetetlen és szétforgácsoló magyar orvosi társadalom mindig gyengének bizonyult."

CHAPTER 1.

1. INTRODUCTION

1.1. Setting the scene

Throughout its 1,000-year history the Hungarian state has been influenced by both its location in the Carpathian basin in Central Europe and the nature of its people, the Hungarians, who form part of the now widely dispersed Finno-Ugric linguistic group. The Hungarian Kingdom – established in 1000 AD when its first king, St. István, who converted the country to Christianity, was crowned – was a powerful state in the medieval period. However it fared less well in the face of attack, and eventual conquest, first by the Mongols (Genghis Khan) and then, in 1526 by the Ottoman Turks, who occupied the middle part of the country for 150 years. After the expulsion of the Turks, the Habsburgs established authority over the territory of the entire country, preserving it by suppressing uprisings in 1711 and 1849. As part of the Austro-Hungarian dual Monarchy, Hungary was on the losing side in World War I, subsequently losing two thirds of its territory. During World War II first the Germans and then the Russians occupied the country, and in 1948 a communist dictatorship, the People's Republic of Hungary, was established under the political and military domination of the Soviet Union. Although an anti-Soviet uprising in 1956 was put down by Soviet troops, after 1968 Hungary partially liberalized its command economy, creating a more liveable atmosphere; the 'most cheerful barrack' behind the 'iron curtain'. This special mixture of relaxed central economic and political control, termed 'goulash communism', distinguished it from other communist countries in the region [9,p.82]. The country regained its independence in 1989 and embarked upon a political and economic transition to reintegrate itself into the 'Western World'. Hungary became a member of NATO in 1999, and it was one of the first of the former communist states to be accepted as a candidate for accession to the EU. [10,p.329; 11]

The current territory of the country covers 93,000 km² (1% of the size of Europe) with more than half the area being lowlands surrounded by mountain ridges and hills. The Duna (Danube) and Tisza rivers, and Lake Balaton, the biggest freshwater lake in central Europe, are the country's main sources of water. Its neighbours are Slovakia to the north, Ukraine and Romania to the east, the Federal Republic of Yugoslavia and Croatia to the south, and Slovenia and Austria to the west (Figure 1.1). [12,pp.22-23]

Figure 1.1. Map of Hungary



Source: World Factbook 2003.

Hungary had 10,175,000 inhabitants in 2002 while, as a result of its stormy history, another approximately 5,000,000 ethnic Hungarians live outside the current borders of the country. The population has been decreasing because births have outnumbered deaths since 1981; the population has aged as the share of the elderly, aged 65 or over, has steadily increased during the past decade, accompanied by a decrease in the share of children under 15 years old (Table 1.1, Figure 1.2). The majority of the population are ethnic Hungarians and Catholic by religion. The largest ethnic minority group, the Roma or Gypsy community, is currently estimated to comprise 200-400,000 people [12; 13].

Table 1.1. Population indicators of Hungary, 1949-2000 (selected years)

	1949	1970	1980	1990	1992	1994	1996	1998	2000
Population (millions)	9.2	10.3	10.7	10.4	10.3	10.3	10.2	10.1	10.0
Live births per 1,000	20.6	14.7	13.9	12.1	11.8	11.3	10.3	9.6	9.7
Deaths per 1,000	11.4	11.6	13.6	14.1	14.4	14.3	14.0	13.9	13.5
Population change per 1,000*	9.2	3.1	0.3	-2.0	-2.6	-3.0	-3.7	-4.3	-3.8
Total fertility rate (children/woman)	2.54	1.97	1.92	1.87	1.77	1.64	1.46	1.33	1.33
Induced abortions per 100 live births	0.9	126.7	54.4	71.9	71.5	64.4	72.8	70.9	60.7
% of under 15 years (A)	24.9	21.1	21.8	20.5	19.4	18.6	18.0	17.5	17.1
% of 65-year old and over (B)	7.5	11.5	13.5	13.2	13.6	13.9	14.2	14.4	14.6
Aging index (B/A x 100)	30.2	54.4	61.9	64.4	70.1	74.7	78.9	82.3	85.4

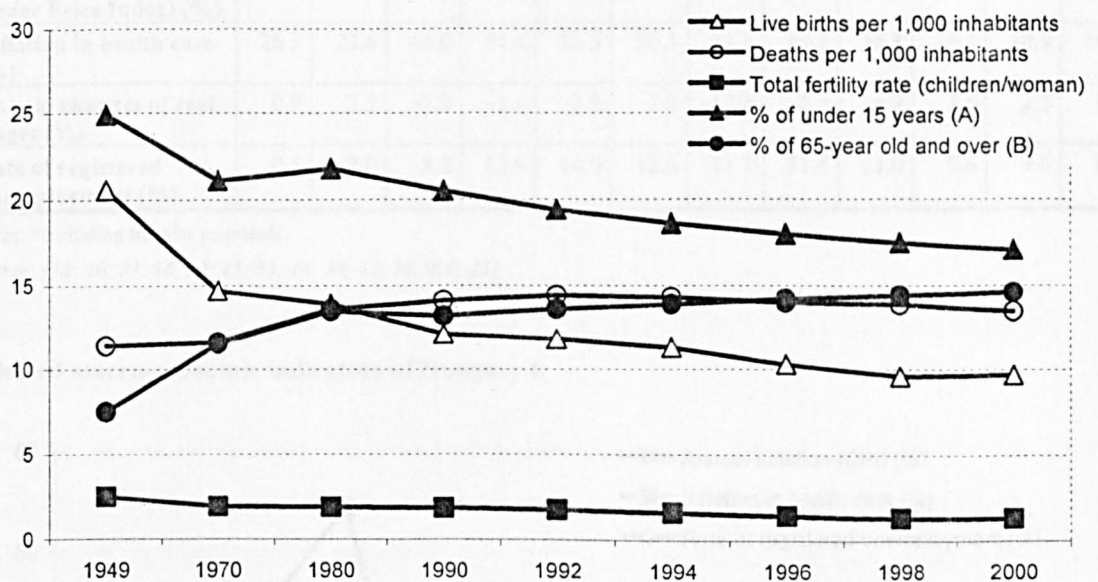
Note: *Excluding international migration.

Source: [12; 14-21]

Since 1990, Hungary has been a constitutional democracy and has experienced political stability, with 4-6 main political parties and coalition governments [22,2(2(1)); 23,31.2]. The 386 seats in the unicameral parliament (National Assembly) are filled

every four years by a mixed majority and proportional electoral system with single-choice voting [24; 25]. Mayors and local government assemblies are also elected for four years, with the elections taking place a few months after the general elections [26; 25]. The public administration system has three levels: central (national) government, counties and settlements (municipalities). The country is divided into 19 counties, each with a population of between 200,000 and 1,000,000, and the capital, Budapest, which has 1,700,000 inhabitants [23,2.9]. However Hungary is still, in many ways, a predominantly rural country with slightly more than 40% of the country's population living in communities of less than 10,000 inhabitants [12,3.51].

Figure 1.2. Selected population indicators for Hungary



Source: [12; 14-21]

The establishment of democratic political institutions in Hungary was relatively smooth compared to some other countries of the region, such as the countries of the former Yugoslavia, where violence destabilized the transition period. The earlier liberalization of 'goulash communism' facilitated a gradual approach to economic and public sector reform, but the transition has proved to be challenging (Table 1.2, Figures 1.3,1.4).

In 1991 GDP dropped sharply, by nearly 12%, and did not begin to increase until 1994 (Figure 1.4). Inflation peaked at 35% in 1991, and reached 29% in 1995 (Figure 1.3). Unemployment rose to 14% in 1993, while real wages fell continuously until 1996, when they were only 76% of their 1989 level (Figures 1.3,1.4). In recent years, however, the trend has reversed. As a result of structural transformation and strict fiscal policy, by 1997 the country began to experience stable economic growth, achieving a

growth rate of 5.2% in 2000 (Figure 1.4, Table 1.2). Both unemployment and inflation fell below 10%, the former in 1998 and the latter in 2000 (Figure 1.3). Real wages have been rising since 1997 (Figure 1.4). Nevertheless, the income gap between the poorest and the wealthiest 10% of the population rose from a 3.5 fold difference in 1970 to a 5.5 fold difference in 1999 [27; 28].²

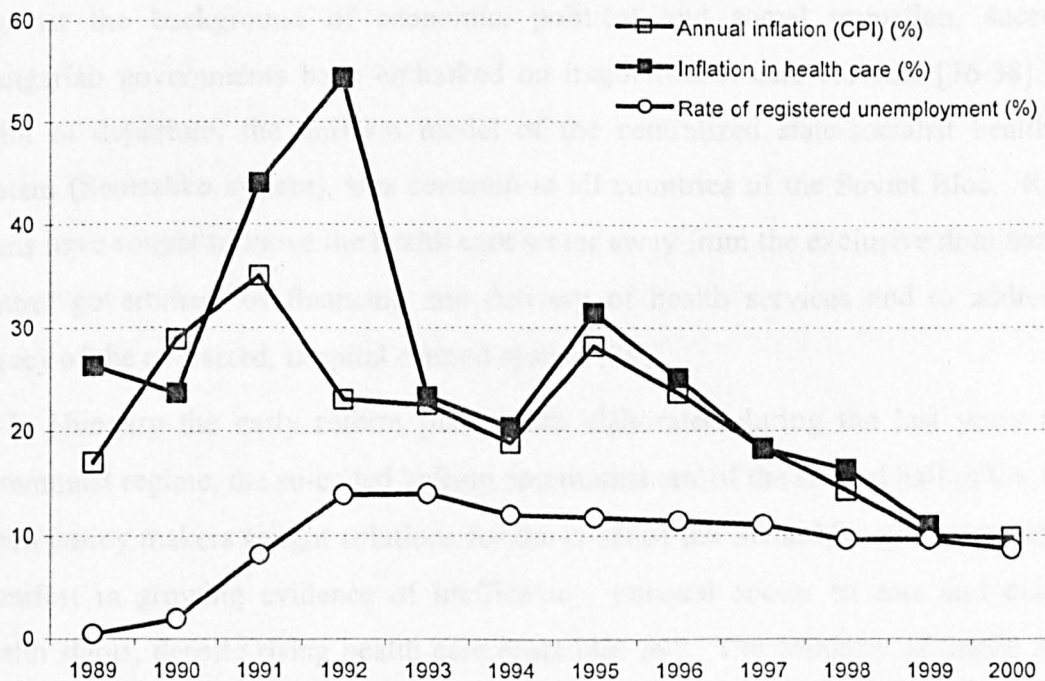
Table 1.2. Macro-economic indicators in Hungary

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
GDP per capita at current prices (US\$)	2,070	3,189	3,197	3,534	3,745	4,046	4,367	4,433	4,504	4,651	4,769	4,621
GDP growth rate (%)	0.7	-3.5	-11.9	-3.1	-0.6	2.9	1.5	1.3	4.6	4.9	4.2	5.2
Public expenditure as % of GDP*	64.6	61.3	66.3	71.8	72.5	74.0	63.8	57.0	56.8	49.9	47.0	46.3
Annual inflation (Consumer Price Index) (%)	17.0	28.9	35.0	23.0	22.5	18.8	28.2	23.6	18.3	14.3	10.0	9.8
Inflation in health care (%)	26.3	23.6	44.0	54.4	23.3	20.3	31.4	25.1	18.3	16.3	10.9	10.0
Annual changes of real wages (%)	0.9	-3.7	-7.0	-1.4	-3.9	7.2	-12.2	-5.0	4.9	3.6	2.5	1.5
Rate of registered unemployment (%)	0.5	2.0	8.2	13.9	14.0	12.0	11.7	11.4	11.0	9.6	9.6	8.7

Notes: *including transfer payments

Source: [18; 30; 31; 16; 32; 15; 33; 14; 34; 12; 35,18.6; 23]

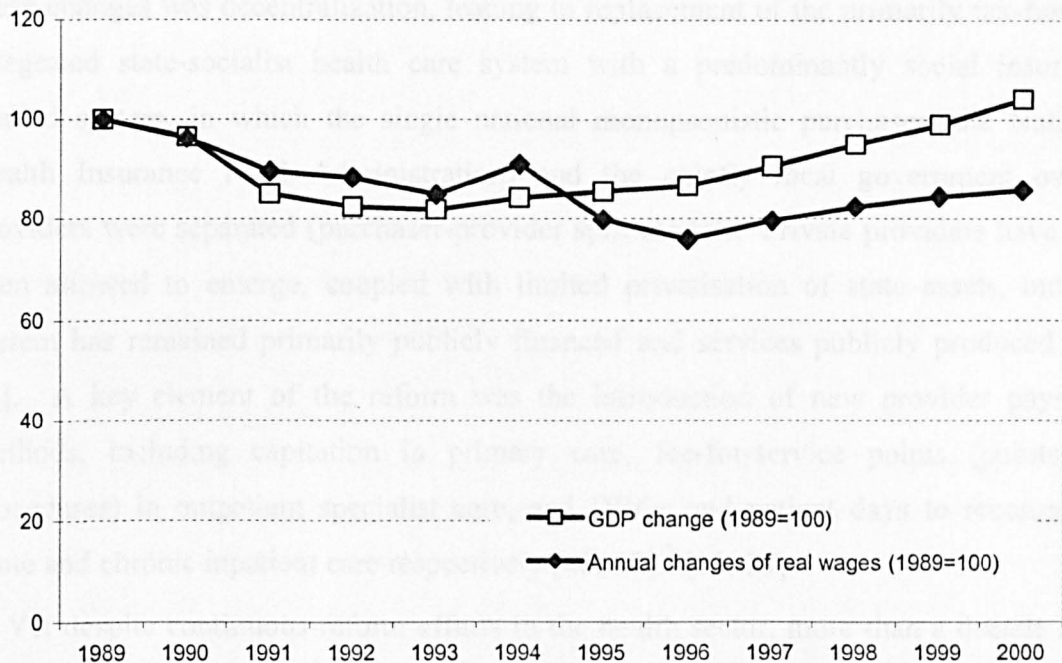
Figure 1.3. Selected macro-economic indicators of Hungary I.



Source: [18; 30; 31; 16; 32; 15; 33; 14; 34; 12; 35,18.6]

² Chapter 2 provides an extended discussion of the context of the health care system and health sector reform, as well as an introduction to the current system in place. For a more detailed description of the economic, political and social context of health care reform see Gaál et al. [11] and Gaál: Health Care System in Transition: Hungary. Copenhagen: European Observatory on Health Care Systems [29].

Figure 1.4. Selected macro-economic indicators of Hungary II.



Source: [18; 30; 31; 16; 32; 15; 33; 14; 34; 12]

1.2. Health care reforms and informal payment: A fly in the soup, but how big and how nasty?

Against the background of economic, political and social transition, successive Hungarian governments have embarked on major health care reforms [36-38]. The point of departure, the uniform model of the centralized state-socialist health care system (Semashko system), was common to all countries of the Soviet Bloc. Reform plans have sought to move the health care sector away from the exclusive dominance by central government of financing and delivery of health services and to address the legacy of the oversized, hospital centred system [39].

In Hungary the early reform plans were elaborated during the last years of the communist regime, the so-called 'reform communist era' of the second half of the 1980s, when policy makers sought solutions for the crisis of the Semashko system, which was manifest in growing evidence of inefficiency, unequal access to care and declining health status, despite rising health care costs [40; 39]. The Ministry of Social Affairs and Health established a unit, the so-called Reform Secretariat, which elaborated a blueprint for health care reform considering the earlier Bismarckian social insurance tradition of the country, as well as the experiences of Western Europe and the USA [36; 41]. The implementation of structural changes also began in this period and continued

after the first free elections in 1990 [42; 43]. Not surprisingly, the main direction of these changes was decentralization, leading to replacement of the primarily tax-funded, integrated state-socialist health care system with a predominantly social insurance funded system, in which the single national monopsonistic purchaser (the National Health Insurance Fund Administration) and the chiefly local government owned providers were separated (purchaser-provider split model). Private providers have also been allowed to emerge, coupled with limited privatisation of state assets, but the system has remained primarily publicly financed and services publicly produced [44; 45]. A key element of the reform was the introduction of new provider payment methods, including capitation in primary care, fee-for-service points (points for procedures) in outpatient specialist care, and DRGs and patient days to recompense acute and chronic inpatient care respectively [46; 47].³ [11; 29]

Yet despite continuous reform efforts in the health sector, more than a decade after the political changes, the former communist countries are still struggling with the problems posed by the process of transition. In Hungary, the experiences of these years have shown that the health services do not yield easy successes for reformers. Indeed, the peculiarities of the health sector, coupled with the adverse legacy of the former regime, have created a difficult puzzle to solve, one element of which remains particularly obstinate. Informal payment, a well-recognised phenomenon in the Semashko system, has survived not just 40 years of communist dictatorship, but 15 years of ongoing health care reform. A former minister of health, speaking in 2001, provides a clear testimony to the problem in his answer to a question by an MP:

"Andor Kiss (MIÉP): Do you trust in Hungarian physicians, or what conclusions do you draw from the findings of an opinion survey?

Some weeks ago a daily newspaper published the results of an opinion survey, carried out on the internet. One of the questions was: "Do you trust in the Hungarian physicians?" The result was shocking... 44% said no...

...Lately, the young aren't attracted by this profession, applications have decreased substantially, and the number of points required for admission [to medical schools] is low. If the Ministry of Health don't do anything, we can get into the same situation as the Norwegians, who haven't got enough medical doctors and must import physicians from abroad, including some from Hungary...

Dr. István Mikola, the minister of health answers:

³ Chapter 2 provides a more detailed description of the evolution of the Hungarian health care system from the roots before World War II, through the Semashko system to the past 15 years of health care reform.

Honourable fellow Member of Parliament! I trust the Hungarian physicians. I myself am a medical doctor, I've worked in several sectors of the health care system, I know them. I think patients trust the Hungarian doctors, too. I wouldn't draw such a profound conclusion from an internet survey... which confused gratitude payment with corruption... I wouldn't like to say, however, that we like the institution of medical gratitude payment, but there is no way to abolish this unfortunate legacy from one year to the other...

I'd like to tell you that medical doctors work altruistically for pittance. Recently I've been addressed by 47 clinicians of the Institute of Traumatology. The letter was signed by a 60-year old colleague, whose gross monthly salary is 98,000 forints⁴... when I see their salary I need to cry... But we do act to change this situation – and this is the institution of gratitude payment, which in fact sometimes generates distrust –, this is why we will submit the bill on... free-lance medical practice, according to which... the medical doctor becomes an independent contractor, and cannot get into a situation, that s/he'd accept money from an insured patient, or to let patients to express their gratitude towards her/him."
[48]

This dialogue offers a good illustration of the ambiguities that surround this issue. Questions of whether informal payment is the product of lack of trust or represents real gratitude, whether it is corruption or not, whether it creates problems or is beneficial to the performance of the health care system, and whether it can (and should) be eliminated in the short or the long term only, have been asked ever since informal payment emerged in the health sector in Hungary. But what exactly is informal payment, and when did it become part of our history?

Ádám [49; 50] reports that the 'custom' of paying medical doctors and other health workers, even though health services were officially free of charge at the point of utilization, is rooted in the establishment of the state-socialist health care system in Hungary.⁵ A 1959 meeting of the Party Council presented the problem as follows:

"The principle, that workers are entitled to high quality health care free of charge... must be put into practice. The abuse, which hits the working class who are entitled to free health care must be abolished... We must fight against the 'widespread system of tips' as well. We have to ensure, that health workers do not behave in ways that patients and their relatives would think that they would get distinguished services if they paid, made a tip or gave gifts. The main weapon

⁴ €400. 1 EUR is equivalent about HUF 250.

⁵ For a discussion of and more precise definition of informal payment, developed in the frame of this study, see chapter 3.

in this fight, however, should not be administrative measures, but the continuation of persistent political indoctrination." [51; cited in 50]

Ádám [50] argued that this resolution of the communist party had laid down two key principles of the policy on informal payment, whose duality has been dominating policy making ever since. First, gratitude payment has to be separated from other, corrupt forms of informal payment, and second, that although both the corrupt and non-corrupt practices should be eliminated, 'administrative' measures (i.e. legal proceedings and sanctions) are inapplicable in the case of gratitude payment. It seems, however, that the policy of "*persistent political indoctrination*" failed to result in the desired behavioural change throughout the following three decades of the regime. The defeat was explicitly acknowledged by the more pragmatic reform communist leadership, which introduced taxation of informal payment, as if tax evasion had been the only problem caused by informal payments [8]. Whilst post-transition freely-elected governments have acknowledged that informal payment has been undesirable, they have continued to rule out 'administrative' measures, hoping that the marketization reform of the health care system would create an environment in which the phenomenon will "*gradually die out*" [52; 37; 38]. The first eight years of democratic government passed without noticeable policy changes, but 1998 seemed to bring a change in policy. The newly appointed minister of health convened a committee of leading academics in this field to study the issue and propose a policy. While this move brought informal payment to the attention of the media for a while, it has not generated any policy change. Not surprisingly, informal payment has remained with us [12].⁶

As well as the distinction between gratitude payment and corruption and the exemption from 'administrative' measures, one of the abiding features of government policies on informal payment is that any solution will take time. Twelve years after the first free general elections, one question seems to be particularly relevant: how much time? And if after twelve years there has not been a noticeable improvement in this area, should we push on with the fight against informal payment and should the goal be to abolish it at all?

1.3. Why does informal payment matter?

To examine how the relevance of informal payment to health sector reform can be established, this study draws on the analytical framework developed by Roberts et al.

⁶ Chapter 2 introduces the history of informal payment in more details.

[53]. The distinctive feature of this model compared to the other similar frameworks available for health policy analysis [e.g.54; 55-60], is its integrated approach to problem definition, which does not just separate causes and problems, tools and objectives, but recognises the equal importance of the policy process and politics in policy decisions and points out the inherently subjective nature of goal setting. Its main limitation is the blurred conceptual differentiation between intermediate and ultimate objectives of health policy, and the potential of the relativist approach to paralyse scientific analysis, which will be discussed briefly along the introduction of the framework.

1.3.1. WHAT MAKES A HEALTH POLICY PROBLEM?

Applying a diagnostic-therapeutic approach to health policy analysis, Roberts et al. raise the question of what makes a problem in health care reform? Using the model of Donabedian (input, structure, process, output and outcome), they argue that problems can be defined at the level of system outputs or outcomes, which are the result of causes at the level of inputs, structures and processes. To put it another way, a problem exists if the health care system does not achieve its 'ultimate' objectives, such as the improvement of health status of the population or enhancing consumer satisfaction. They argue that behind these ultimate objectives, or as they put it, 'performance criteria', there are complex causal chains of variables, which finally lead us to the causes of problems. The application of this framework to the subject of this thesis suggests that informal payment in itself is not a problem, but a possible cause of problems by its impact on system performance, in terms of ultimate policy objectives. To establish its relevance to health policy and health sector reform, first we have to establish whether it has an undesirable impact on system performance, for instance poor health status or dissatisfied consumers.

But what exactly are these objectives and how do we know which matter? Roberts et al. [53] follow a more complex approach in the definition of objectives, than do other theorists, such as LeGrand et al. [56], Aday et al. [55] and Hurley et al. [60], who essentially apply the efficiency and equity concepts of welfare economics [54] to health care. Roberts et al. distinguish two sets of objectives, intermediate and ultimate. They list four ultimate objectives, which include the reduction of inequalities in the health status of individuals and protection against the cost of ill-health, besides the aforementioned improvement of the health status of the population and consumer satisfaction. Within the group of intermediate objectives they assemble a somewhat extended list of efficiency and equity-related concepts, such as access to care, technical

efficiency, allocative efficiency, cost-effectiveness, sustainability and quality. Although they devote little discussion to the reason for this separation – and indeed it can be argued that efficiency is just an intermediate objective, since maximising any kind of population level outputs take place in a resource constrained environment, whilst at the same time different equity concepts appear at both levels⁷ – they clearly argue two important points using these sets of objectives as illustrations. First, problem definition, which relates problems to policy objectives, is inherently a normative process. It entails value judgements, which depend on one's moral-philosophical standpoint. Second, what follows from this is that the definition of the same concepts, efficiency and equity, can be subject to different interpretations depending on the preferred moral and philosophical view.

They distinguish three main groups of ethical schools of thought, consequentialism, liberalism (rights-based approaches) and communitarianism, within which further viewpoints are described. For instance consequentialists advocate the principle of 'the greatest good for the greatest number', but that good can differ whether individuals are thought to be the best to judge of their own happiness, which is the key tenet of "*subjective utilitarianism*", or else ordinary people are thought to be ignorant, short-sighted, careless and to make decisions that are not in their best interests and so experts have to determine what is good for them, which is the basic idea behind "*objective utilitarianism*".

Roberts et al. [53] argue that each of these 'intellectual traditions' has very different implications for the objectives that health care systems should achieve, and this applies not just to the choice between equity and efficiency, but to the interpretation of these concepts. For instance all utilitarians favour efficiency, which requires the maximisation of overall total benefits compared to costs, but efficiency has a different meaning for a subjective and an objective utilitarian. A subjective utilitarian would like to maximize consumer satisfaction on the basis that individuals are the best judges of their own welfare, a concept known as allocative efficiency in welfare economics. An objective utilitarian, however, would like to maximize well-being, measured as health status. This is a different concept of efficiency, called cost-effectiveness, which deviates from the original notion of allocative efficiency not just that it assumes that

⁷ One can argue, that this separation makes sense inasmuch as ultimate objectives are to maximise what one would like to achieve, and it cannot be maximised if we are not getting out the most from scarce resources, or that providing equal access to care will eventually reduce inequalities in health (hierarchical relationship between objectives), but the rationale of the separation of intermediate and ultimate objectives is not addressed by the authors themselves.

interpersonal utility comparisons are possible and individuals have the same utility function [54, pp.111-112], but that this utility depends only the health gain they acquire. It is also called the extra-welfarist approach to efficiency [61]. Similar differences of interpretation can be observed concerning equity, which is concerned with the fair or just distribution of benefits and costs amongst individuals or groups in society rather than maximisation of benefits at the population level. Roberts et al. argue [53] that distributional issues are the prime concerns of liberals, who seek to respect the autonomy of individuals to make their own choices. Both negative right liberals, or libertarians and positive right liberals, or "*egalitarian liberals*" advocate that each human being is equally entitled to something, but not necessary to health or health care.⁸ From a libertarian moral-philosophical point of view, seeking to ensure that others do not interfere with the right of individuals to choose for themselves how to live their life, everybody has a right to the possession and enjoyment of justly acquired (work, inheritance, gift or exchange) income or wealth, which implies that inequalities in health are not unfair. In contrast, egalitarian liberals argue that a certain level of health is a prerequisite to making real choices concerning our life. Consequently all members of society should be entitled to a certain level of health as a prerequisite for making a meaningful choice. What this level of health is, and whether it is health itself, or instead health care, is debated by different writers, not just on grounds of feasibility, but of principles, since redistribution may force choices and individuals' choices may affect their health.⁹

The implication of this relativist analytical framework for informal payment is that policy makers with different ethical views would judge differently whether or not

⁸ For a more extended discussion in a similar vein see Pereira [62].

⁹ A detailed critique of this classification of moral theories is beyond the scope of this thesis, but it may be helpful to mention an example here. The category of "*communitarianism*" seems to mix two important classification criteria. First, what the authors argue, communitarianism emphasise the virtue of the good character, or how people should behave. This introduces another set of values (objectives), which differentiates communitarianism from liberalism and utilitarianism. Second it is the community that decides what these values are. In this later respect, Roberts et al. [53] distinguish two forms of communitarianism. The relativist communitarians, who acknowledge that different communities can have different visions on the good character or the good society, whilst universalist communitarians believe that their vision is the only good, which should be extended to others. I would argue that this latter differentiation has a more general descriptive importance, which can be extended to the other moral-philosophical views. The question in this respect is not what the objectives are, but who sets these objectives. For instance, libertarians and to a certain extent subjective utilitarians believe, although on a different basis, that individuals should pursue their own objectives, objective utilitarians believe that experts have to determine these, while communitarians believe that it is the community. But should different communities follow the same objectives or respect each other's choices? At the level of communities a liberal or a utilitarian can be as universalist as a universalist communitarian is.

informal payment causes a problem, and what this problem is.¹⁰ Certainly, it seems necessary to clarify in any policy debate whether differences in views of various policy proposals are due to divergent views on the appropriateness of the policy for achieving agreed objectives, or are attributable to differences in the desirability of the objectives, themselves. Nonetheless, one can argue that a relativist approach like this entails the risk of paralysing meaningful policy analysis if there is no consensus on objectives. Furthermore, policy makers may not even know what they really want to achieve. This is not necessarily because they are ignorant, but because there is something appealing in each of these moral-philosophies. The World Health Report 2000 is a good example of this stand [58]. The authors of the report delineate a very similar set of ultimate objectives (or as they put it goals) as do Roberts et al. [53], but they consider not just overall goal achievement, e.g. the average level of health status, but also its distribution among the population. In turn, experts construct an overall index, which is calculated from the individual goal achievements, using specific weights. Finally, they incorporate efficiency considerations by relating the overall attainment to the resources spent in the various health care systems. According to the terminology of Roberts et al. [53] the World Health Report has developed perhaps the most unique form of moral-philosophy, an egalitarian liberal objective utilitarian universal communitarian approach, with the distinctive feature that it synthesises equity and efficiency. Most notably, however, the World Health Report suggests that each country has to follow not just the same health policy objectives, but also a pre-defined balance (priority) between them.

In this study I take a middle position, advocated by certain economists [54,p.112], that says that experts should analyse the likely effect of policies on all the important objectives without taking a stand on which one of them is more or less important than others.¹¹ This position assumes that there is an agreement on the objectives to be considered. Here Hungary provides a good example. In Hungary there seems to be a general consensus among mainstream political parties concerning the main objectives of

¹⁰ One may criticise the analytical framework that it virtually takes a consequentialist approach, when defines problems at the level of outputs or outcomes. For instance choice is typically a value linked to the process of health services. Nevertheless one may regard all intrinsic objectives as outcomes of the system.

¹¹ Three points may be worth mentioning here. First, that the ethical positions described by Roberts et al. [53] may seem to be committed to a particular policy objective, but that does not mean that they have nothing to say on other objectives. For instance, the objective utilitarian (extra-welfarist) approach does imply considerable redistribution, since access and valuation should be linked to need rather than ability to pay. Second, different ethical positions may imply the same solution, when it comes to practical implementation. For instance subjective utilitarians and libertarians both prefer the market as a resource allocation and distribution mechanism. Third, the various areas of the health sector can in fact work on different principles within the same health care system.

health policy. These include patients' rights, effectiveness, cost-effectiveness and equal access for equal needs (Box 1.1). Nonetheless, there is no attempt to prioritise amongst these objectives in the relevant laws and regulations, showing how it is difficult to agree on priorities but less difficult to agree on the objectives that count.

Box 1.1. Health policy objectives in Hungary

Article 1 and 2 of *Act CLIV of 1997 on Health* defines the principles of (a) the protection and promotion of patient rights, (b) equal access to health services for equal needs, (c) the effectiveness of health care interventions, based on scientific evidence, and (d) the cost-effectiveness of health services, on the basis of which the health care system has to be built [1]. Equity seems to be a defining objective backed up by a wide social consensus, since the state-socialist health care system's fundamental principle that access to care should not depend on ability to pay has remained unaltered throughout the period of successive reform governments. *Act LXXXIII of 1997 on the Services of Statutory Health Insurance* further clarifies the practical implementation of this equity objective [2]. Social insurance financing of health care not just removes ability to pay as a barrier to access to care, but the law explicitly prohibits giving priority to patients who would be willing to pay extra, should there be a waiting list [2,20(3); 1,9(4)]. In the frame of the statutory health insurance scheme each patient should receive the same standard of care as far as clinical quality is concerned, but they are allowed to pay extra for higher quality hotel services, like one-bed or two-bed rooms with telephone and colour TV [2,3,23(g)]. Moreover, social insurance contracted health care providers cannot charge extra for medical treatment that are included in the benefit package, except for the centrally determined and regulated cases of co-payments [2,21,23; 3]. Only few services are excluded totally from the benefit package. These are stipulated in Article 18 of the Act, and in *Decree No. 46/1997. (XII. 17.) NM* [4].

Hence, according to the logic of the Roberts et al. framework, but drawing not on their classification and definition of objectives, but on the Hungarian laws and regulations, informal payment matters if it causes inefficiency (cost-effectiveness), prevents access to care or detrimentally affects (the clinical and/or service) quality of care or patient rights (effectiveness, responsiveness). Although, as we have mentioned before, there are debates over the definition of various objectives, as well as their relationships to each other (for instance whether clinical effectiveness and quality can be regarded as a separate objective or they are part of efficiency), the detailed discussion of these issues is beyond the scope of this thesis. Instead, we note that Aday et al.'s [55] definition of effectiveness and quality, the extra-welfarist notion of efficiency [61] and the definition of the World Health Report 2000 for responsiveness [58] provides a relatively consistent framework that are used here, while the conceptualisation and operationalisation of the 'equal access for equal needs' principle is discussed extensively in chapter 7.

But does informal payment really have such impact on system performance?

1.3.2. CURSE OR BLESSING: THE IMPACT OF INFORMAL PAYMENT ON THE PERFORMANCE OF THE HEALTH CARE SYSTEM

The impact of informal payment on the performance of the Hungarian health care system has always been disputed, not just at the level of policy-making, but amongst academics and researchers. For instance, researchers such as Orosz [39] and Bondár [63] have argued that informal payment has a central role in ensuring that the system functions. Balázs [64] went even further by talking about informal payment as an organising principle, the removal of which could easily result in the collapse of the system. In contrast, researchers such as Blasszauer [65], Ádám [66; 50; 49; 67; 8] and Lengyel [68] emphasised the immorality and illegal nature of the phenomenon and argued for stricter enforcement of laws to eliminate informal payments. Another good example is the dispute about the interaction between new provider payment methods and informal payment. Bordás [52] argued that output-based provider payment methods would eventually drive informal payments out of the system, while Csaba [69] thought that they could even increase them. These contradictory opinions suggest that there is disagreement amongst researchers on the nature of informal payment and the incentives it introduces into the system, since eventually these determine its impact on system performance.

Roberts et al. [53] argue that behind performance failures there are complex causal chains, which should be explored and analysed to identify the possible points for interventions.¹² In the case of informal payment, however, these cause-effect relationships are equivocal, because there are competing claims on the causes of the phenomenon itself and the motivation of patients and physicians, discernible in the speech of the former minister of health. The images of grateful patients giving thanks for being cured and the corrupt physician, who effectively extorts payment imply different answers to the question of why people give, which in turn have differing

¹² They argue that in the causal chains there are certain variables that are amenable to government intervention. Because the adjustment of these variables can eventually change system performance, they call these variables "control knobs". They propose four main control knobs: financing, payment, organization and regulation. These knobs have many different settings, whose combination, Roberts et al. [53] argue, eventually determines, how a particular health system performs in relation to the aforementioned objectives, although the adjustment of a control knob usually affects other health policy objectives and not just the one, for which improved performance is sought. For instance, the options of financing, i.e. the settings of the health care financing control knob, comprise taxation, social insurance, private insurance, user fees (direct payments, out-of-pocket payments) and community financing. In turn, each of these options has special characteristics that can influence system performance. Using this framework, informal payment can be understood as a financing option (user charges), as well as a method of payment (fee-for-service), which is one possible way to model its potential impact on system performance. Whether informal payment is virtually a form of user fee and fee-for-service has long been debated and crucial to decide on what should be done about it.

implications on the impact of informal payments on system performance and consequently on what to do about it and how.

If informal payments are given truly voluntarily, and physicians and other health workers do not provide any better services to paying patients, one can say that informal payment is a desirable form of private health care financing, since it brings more funds to the health sector without introducing the equity problem of formal co-payments. This benign informal payment is called gratitude payment, a term, which, according to Ádám [49], was coined by the medical profession in the 1950s. Moreover, if these conditions pertain, neither does gratitude payment adversely affect efficiency, but provides an incentive for physicians to stay in the profession, and ensures a sustained supply of human resources at least in those specialties where gratitude payment is substantial [52]. These assumptions about informal payment, which emphasize the benign nature of the phenomenon, can be summed up as the 'donation' hypothesis of informal payment. However, if any form of coercion is associated with informal payment, it is the worst possible form of private financing, since it is not possible formally to grant any exemption to the poor, given the informal nature of the phenomenon [70]. Informal payment could well become a barrier to access to care. According to this 'fee-for-service' hypothesis, informal payment can worsen the efficiency of service provision too, if doctors feel obliged to provide otherwise unnecessary services just to please the patients who paid [71; 63; 69].

As far as policy making is concerned, the 'donation' hypothesis, with its assumed cultural roots, implies that informal payment cannot easily be eliminated from the system [72], but this is not absolutely necessary, given the benign nature of the phenomenon. In contrast, if informal payment is instead a fee for service, policy makers should act on the problems it causes, as the World Health Report 2000 put it:

"...A widespread example is the condoning of public employees charging illicit fees from patients and pocketing the proceeds, a practice known euphemistically as "informal charging". Such corruption deters poor people from using services they need, making health financing even more unfair, and distorts overall health priorities." [58,p.xv]

In summary, whether informal payment is a curse or a blessing for the Hungarian health care system depends on why patients give and why physicians and other health

workers accept it. This question lies in the hearth of the dispute on informal payments and has been selected as the central theme of this study.¹³

1.3.3. POLITICS OF THE POLICY PROCESS: THE IMPACT OF INFORMAL PAYMENT ON HEALTH SECTOR REFORM

As well as exploring the normative approach, Roberts et al. [53] emphasize that what reaches the policy agenda does not necessarily coincide with normatively defined problems. They argue that the cultural context, which makes various topics taboo and others salient, the various actors, such as issue entrepreneurs, or the media and the issue-attention cycle, are all examples of forces that influence problem definition.

The recognition of private interests and politics in the policy process helps to point out another aspect of the possible health policy importance of informal payment. Even if informal payment has no undesirable consequences on the performance of the health care system, we should consider the impact of the interests it creates on the reform process. Regardless of the exact nature of informal payment, it makes the recipients better off and that may in turn create resistance to reform measures that aim to change the status quo. Thus, informal payment could be an obstacle to health care reform [64; 73; 9; 74].

1.3.4. LARGE ENOUGH TO BOTHER? THE EXTENT, MAGNITUDE AND DISTRIBUTION OF INFORMAL PAYMENTS

So far we have argued that informal payment matters only if the incentives it introduces make the health care system fail to achieve policy objectives and the interests it creates block health sector reform efforts. However, one can argue that if the overall magnitude of informal payment is small it does not distort incentives and system performance so much and does not create so strong resistance to change that would justify policy makers' attention. Indeed, the magnitude and distribution of informal payment is key to whether informal payment is regarded as a source of policy concern. Thus, this study will also address the scale of informal payments to the extent that it justifies any further research into the phenomenon.

1.3.5. CONCLUSIONS: THE POLICY IMPORTANCE OF INFORMAL PAYMENT

In summary, this section has examined why informal payment matters for health policy and health sector reform. Applying the analytical framework developed by Roberts et

¹³ See chapter 3 for a more detailed discussion of the theories of informal payment.

al. [53] to informal payment, first we have argued that it only matters if it alters the operation of the health care system so that the system does not achieve its goals (unsatisfactory system performance), and second if it influences health sector reform through the interests it creates, with the provision that the scale of the phenomenon matters too. Using the terminology of Roberts et al. [53] informal payment is not a problem itself, but a possible cause of problems that are manifest in failures to achieve health policy objectives. Whilst moral-philosophies address different health policy objectives that eventually influence whether a particular aspect of system performance is considered a problem or not, we have argued that policy makers are not necessarily committed to a single ethical position, rather a mixture of them, although priorities between the various health policy objectives are often neither clear nor explicit. Hungary offers a good example, since there seems a general agreement amongst mainstream political parties about the objectives that count, which include both efficiency (cost-effectiveness) and equity (equal access for equal needs), but there are no explicit means of trade-off between the two. Nevertheless, whether we think about informal payment as a 'donation' or a 'fee for service' implies not just totally different impacts on these policy objectives and consequently justification to act, but different policy options to eliminate the phenomenon.

1.4. What do we know about informal payment: further complications for policy-making

Applying the analytical framework of Roberts et al. [53] to the subject of this study, I have argued in the previous section that what motivates patients and physicians to give and accept informal payments in the Hungarian health care system fundamentally determines whether policy makers should pay attention to this phenomenon at all. However the exact nature of informal payment has long been disputed amongst policy makers and researchers alike. Indeed, a benign gratitude payment has very different implications for policy making than a fee for service with its potential to deter the poor from utilising care or induce the provision of unnecessary services. Although these working hypotheses inevitably simplify reality, they make the ambiguities that surround the issue particularly evident.

Unfortunately the scarce empirical evidence offers little help in clarifying the situation. Findings on the scale of informal payments are inconclusive. For instance a household survey by Bondár and Ékes [75] estimated the yearly total amount of informal payment in 1994 as almost twice as much as the estimate from the household

survey of the Hungarian Central Statistical Office [76]. The available evidence concerning the motivation of patients and doctors [77-82] is equally inconclusive and contradictory, whilst other areas, such as the actual impact of informal payment on access to care, have remained by and large unexplored. For instance Tóth et al. [78; 81] and Csapó [80] found gratitude by far the most frequently mentioned reason for paying physicians informally, whilst other studies, including Tóth et al. [77] and Dobossy et al. [79] arrived at the opposite conclusion. Moreover, in a qualitative study Szabó [83] found that even physicians thought that the majority of patients paid in expectation of better care.¹⁴

1.5. Rationale, overall aim and focus of the research

This study takes its starting point from this unsatisfactory situation. Informal payment is a long-standing phenomenon in Hungary that has long been recognised as an issue by policy makers, but its double image has created a confusing situation in which both its real nature and scale have remained uncertain. The existing research accurately reflects this ambiguity. Both the theoretical debate and the scant empirical evidence are fraught with contradictions and inconclusion, whilst important aspects of the phenomenon, such as its impact on system performance have remained largely unexplored. It is now time to try to create some clarity, first by systematically reviewing available knowledge and second by filling in some of the most important missing pieces of empirical evidence.

1.5.1. AIMS AND OBJECTIVES

The aim of this study is exploration, description and explanation of the phenomenon of informal payment [84], in order to support informed (evidence-based) policy-making in this area. To achieve this aim the research has pursued the following objectives within the following framework.

First, the broad focus of the study was set out and, on the basis of the literature about the theoretical debates, a theoretical framework was developed and used to outline a research agenda, to select research questions and to formulate hypotheses. Second, the available evidence on informal payment was reviewed and summarised. Third, in light of the empirical evidence, research questions were refined and research methods were selected. Fourth, the research aimed to collect empirical evidence to allow the theory to be refined and policy proposals formulated. Whilst this approach may seem to be

¹⁴ See chapter 3 on the review of the theories of informal payment and chapter 4 on empirical evidence.

mechanistic, it must be noted that the process was rather iterative than sequential, and experiences from one phase fed back to others.

1.5.2. FOCUS AND RATIONALE OF THE RESEARCH

The discussion on the importance of informal payment from the policy-making point of view has already shown that the magnitude of payment and the impact on health sector reform and system performance taken together make informal payment a source for policy concern, but the latter crucially depends on what motivates patients and physicians in the transaction. As mentioned before, there are ambiguities concerning why patients give informal payment, which have been summed up in two rival theories. The 'donation' hypothesis is based on the assumption that patients pay because they are grateful for being cured. In contrast the 'fee-for-service' hypothesis considers informal payment as a means to get better services than they expect to receive without payment. These rival hypotheses imply markedly different consequences for the efficiency and equity of the health care system as well as suggesting conflicting policies concerning what to do about it. Given that the available empirical evidence pertaining to motivation is not just scarce, but inconclusive and contradictory, the motivation of patients and physicians is selected as the main theme of this thesis, beside the extent, magnitude and distribution of informal payments, which are important, as argued before, to establish the policy relevance of the phenomenon. Nonetheless, the double focus of this study is complemented with further aspects of informal payment, as the motivation issue is assessed not just directly, but indirectly. For instance, if the gratitude payment concept is valid then informal payment should not prevent access to care, hence study of the impact of informal payment on equity can indirectly inform us about the validity of the gratitude payment concept.

Nonetheless, it is not just the lack of evidence that justifies further research in this area. Although the majority of researchers in Hungary dismiss the validity of the gratitude payment concept [64; 9; 70; 71; 63; 52; 85; 67], the idea is firmly embedded in society and especially favoured by many physicians. For instance the Code of Ethics of the Hungarian Medical Chamber declares that *"the expression of gratitude, which accompanies recovery from illness, saving of lives and the birth of a new life is not subject to coercion and is based on free will"*. It goes further by saying that *"one of the causes of gratitude payment is the humiliatingly low salaries of medical doctors"* and *"within certain limits" gratitude payment is legal and legitimate* [86,73-79].

Moreover, study of informal payment has even more relevance today than it had at the beginning of post-transition health care reform in Hungary. During the transition period economic recession and fiscal deficit have made cost containment an overwhelming priority, but since 1997 the country has been enjoying healthy economic growth (Table 1.2) that may open the gate to increased health care spending. There is a grave risk, however that the performance of the health care system will not improve significantly unless policies are designed on the basis of evidence.

1.5.3. INTERNATIONAL RELEVANCE OF STUDYING INFORMAL PAYMENT

As well as policy-makers in Hungary, other countries may benefit from the study of informal payment. Although the English language literature was extremely limited in 1997 when I started to work on the issue, the available evidence at least confirmed that many of the former communist countries, such as Poland, Romania and Bulgaria had been struggling with the same problem [87; 88; 74]. The countries of Central and Eastern Europe (CEE) had common health care systems, i.e. they shared a starting point with the same roots and problems. On the other hand, some countries opted for very different tools to tackle these problems. Hence the evaluation of experiences of health care reform in one country could yield useful lessons for the policy makers of others. Comparisons between the countries of the region can offer valuable insights about the applicability of various reform measures.¹⁵ Moreover some anecdotal and empirical evidence suggested that informal payment was not an exclusive feature of the state-socialist model of health care systems as was reported from other countries such as Greece [89-92].

Since then the literature on informal payment has been expanding [93-95], reflecting a growing international interest in the issue, led by, among others, the World Bank and the World Health Organisation [96; 97; 58]. The World Health Report 2000 refers to "*informal charging*" as a widespread phenomenon [58]. Amongst others, informal payments have been reported from Uganda [98], Bangladesh [99] and China [100; cited in 101]. Indeed, in international training programmes I too have encountered

¹⁵ This is not to say that meaningful comparisons can be made between all countries of the former Soviet Bloc, for instance between the Czech Republic and Georgia. In this respect, countries can be divided at least into two groups. In the first group are countries that have achieved a relatively quick and easy transition to democracy and market economy, including Poland, Czech Republic, Slovakia, Slovenia, Romania, the Baltic States, Hungary and maybe Bulgaria and Croatia. That is the economic recession of the transition period did not result in the collapse of the economy, or the breakdown of law and order. The rest of the countries may form the other group, in which countries are (have been) struggling with the collapse of the economy, like Georgia and Ukraine or political instability, like in the countries of the former Yugoslavia (except for Slovenia, and maybe Croatia). (See Chapter 3 for more details)

participants, who came from countries outside the CEE and Central Asian regions, and mentioned informal payments as an issue to be addressed in their health care systems.¹⁶ It seems that informal payment is a world-wide phenomenon, which many low and middle income countries struggle with [102; 103; 95].

I have argued before that informal payment cannot be understood without exploring the motivation of patients and physicians and that this issue has remained contentious in Hungary throughout the long history of the phenomenon. Whether or not gratitude motivates informal payments may not be a dilemma in all of these low and middle income countries, but some evidence suggests that the gratitude payment concept is not just a Hungary-specific custom or societal rationalisation. Similar questions have been posed in other countries such as Poland and Bulgaria [104; 105; 74], and the cultural roots of the phenomenon have been suggested in the Central Asian Republics of the Former Soviet Union (FSU) [96; 97]. The situation in Hungary shows remarkable similarity with Bulgaria, where the guidelines of the Bulgarian Physicians' Union differentiate between *ex ante* and *ex post* payments, condemning the former as unethical, but accepting the latter as the right of patients [74,p.91].

1.5.4. PERSONAL MOTIVES

While the list of possible beneficiaries of a study on informal payment is longer than I had originally thought, the motivation to undertake this research comes partly from personal factors. As a medical student I had to experience what informal payment meant in real life, and its humiliating nature pushed me away from clinical practice. I have chosen health services management with the ambition of contributing to changing the system, but in studying health services management I have had to realise that anyone who embarks on health sector reform inevitably encounters informal payment. This somewhat embarrassing thought has not just remained with me, but was later strengthened by my teaching experiences, as a member of the academic team of the newly established Health Services Management Training Centre at Semmelweis University.¹⁶ For instance, in the dozen institution-based management development programmes in which participants have to present individual management development

¹⁶ Beside the two-year MSc level training programme, the Centre offers a wide variety of continuing education programmes, from short, one or two-day courses to long, institution-based management development programmes, as well as international courses in cooperation with leading universities and the World Bank Institute. The international cooperation extends to research activities, including for instance the out-of-pocket payment study, whose findings are presented in the frame of this thesis.

projects, informal payment has frequently come up during the discussions as an issue either explicitly or at least implicitly.

1.6. Conclusions

Although informal payment has long been recognized as an issue in the Hungarian health care system, it is not clear whether it causes real performance problems and on what scale. Consequently it is not clear whether it should be eliminated and if so, what to do about it.

This study aims to support evidence based policy making in this area with a review of the available literature, the development of an explanatory theory of informal payment and the collection and analysis of empirical evidence focusing on the scale of informal payments and the motivation of actors with an emphasis on the validity of the gratitude payment concept. The theoretical framework puts informal payment into a broader system context that will facilitate further research. Hence in many respects this study aims to prepare the ground for further studies in this field.

1.7. The structure of the document

The aim of a PhD thesis is to generate new knowledge in the field of study concerned. In this respect the document has two main parts. The first part, in chapters 2 to 4 provides contextual information and sets out the theoretical underpinnings for the empirical research implemented in the framework of this study, whose findings are presented in the second part of the thesis, in chapters 6 to 8.

The novel elements of the first part are presented in chapter 2 and 3. Following this introductory chapter, chapter 2 describes the current organisational structure of the Hungarian health care system, provides an overview of recent health care reform and summarises the history of informal payment. The chapter is original insofar as it is based on documentary analysis of laws and regulations and the analysis of published official statistics. Chapter 3 conceptualises informal payment using Hungarian and international literature. One of the novelties of this chapter is a proposed new definition of informal payment, which has emerged out of the realisation of the shortcomings of existing definitions, especially as they make international comparisons difficult if not impossible. Chapter 3 also develops a new theoretical framework on the basis of the existing Hungarian literature and Hirschman's [106] theory of exit, voice, loyalty and the theory of government failure [54] from which research questions and hypotheses are

formulated. The novelty of this explanatory framework is that it not only synthesises the existing thinking on informal payments, but it puts the phenomenon into a broader system context. The first part of the document ends with chapter 4, which examines existing evidence, confronts this evidence with the research questions and hypotheses and helps to refine them.

The second part of the thesis, which covers the empirical part of the study, begins with chapter 5, which presents the final research questions and hypotheses that are addressed by means of empirical research. Chapter 5 also elaborates on the selected research methods. In turn, the data that have been collected are analysed and findings are presented and discussed thematically in relation to the previously developed hypotheses.

Chapter 6 deals with the extent, magnitude and distribution of informal payment. The analysis brings together the findings of the published empirical evidence, expert opinions, official statistics, secondary analysis of certain surveys and the findings of a household survey carried out in the framework of this study. The aim of this chapter is to demonstrate the importance of the phenomenon in terms of its scale.

Chapter 7 relates the gratitude payment concept to access to care. The definition of gratitude payment implies that it should not prevent access to care in any way. To assess the consequences for equity of informal payment, the household survey addressed the issue different ways: whether utilization of health care was delayed or deterred for financial reasons, whether money was a significant factor in uncompleted treatment and whether the cost of care placed a substantial burden on households, requiring, for example, use of savings or borrowing or selling household assets. The analysis is complemented with official statistics and the secondary analysis of previous surveys to assess the cost burden of informal payments on poor households and the differences in terms of the service provided.

Chapter 8 directly addresses gratitude as a motivation factor. Asking why patients give, several previous surveys found gratitude as the most frequently named option, which seems to support the donation hypothesis. It is argued, however, that this answer does not necessary match the definition of gratitude payment. Respondents may rationalize their previous actions later, if they felt the situation embarrassing, or they just adopt the most convenient option where they felt some gratitude although other factors may also have played a role in their decision to pay. To address this potential inconsistency, the research combined quantitative and qualitative methods. First, in the

framework of the household survey, the question of 'why' was posed and those who answered gratitude or custom only, or the combination of the two ('non-coercive' reasons) were asked to participate in an unstructured interview. The analysis focused on discrepancies between the stated motivation in the survey and the comments in the interviews. This chapter also explores the motivation of those receiving payments using unstructured interviews with physicians.

Finally, chapter 9 summarises the main findings of the research, and their implications for policy making and the need for further research.

CHAPTER 2.

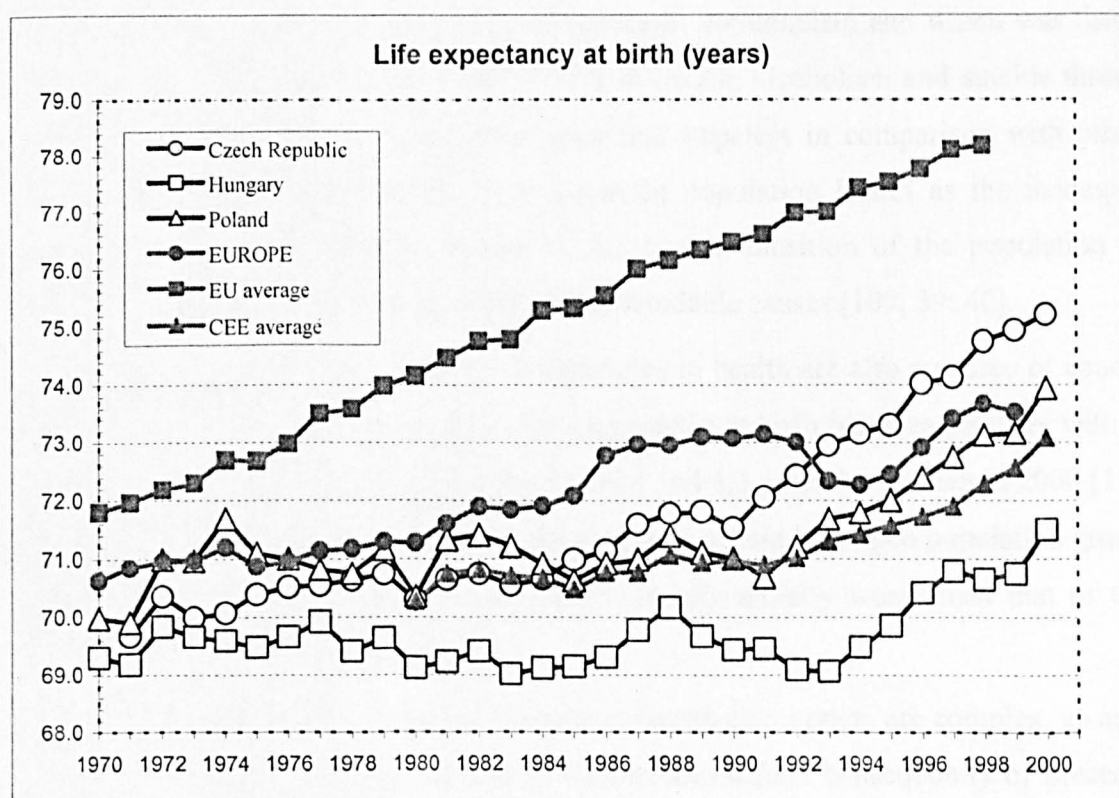
2. INFORMAL PAYMENT IN CONTEXT

The aim of this chapter is to place informal payment in the context of the Hungarian health care system and in particular the changes that have taken place in the past 15 years. The first section briefly discusses the health status of the Hungarian population and is followed by an outline of the current organisational structure of the system and its evolution from the pre-war period through the crisis of the state-socialist system to the stage of recent health care reforms (Appendices A1 and A2 discuss these topics in more details). The chapter closes with a brief account of the history of informal payment, exploring successive government policies and the academic perspectives that have been brought to bear upon it.

2.1. Health status of the population

Since the end of World War II the health status of the Hungarian population has passed through four main phases (Figure 2.1).

Figure 2.1. Comparison of life expectancy at birth, 1970-2000



Source: [107]

The first period, until the end of the 1960s, saw a major improvement that brought life expectancy to a level comparable with the more developed Western European

countries. Yet while life expectancy continuously improved in Western European countries during the 1980s, it stagnated in Hungary. The fall of the communist regime brought about a third period, which was characterised by a marked decline in health status, further widening the gap between Hungary and countries of the EU. Nevertheless, a late recovery started in 1994, and since then a steady improvement in life expectancy has occurred, which at least ensured that the gap between Hungary and its neighbours has not increased.

Life expectancy at birth in Hungary, however, remains among the lowest in Europe, with high mortality among middle-aged men being the most important factor explaining this gap. In 1993, 16 out of 1000 men between the age of 40-59 years died, a rate twice as high as in 1970 [20; 31].

The immediate causes of death that account for the gap with the West include cardiovascular diseases and external causes, particularly suicide, high levels of lung cancer and cirrhosis, which are not surprising in light of the unhealthy Hungarian lifestyle, especially diet, smoking and alcohol consumption [107].

Kopp [108] offers an interesting explanation for these self-destructive tendencies. She links the increasing income inequalities and decreasing social support – which characterized the liberalization policy of ‘goulash’ communism and which was further enhanced by the economic transition – with ill-health, alcoholism and suicide through depression, i.e. feeling one’s situation poor and hopeless in comparison with others. Nevertheless, health services do play a part in population health as the inadequate response of the state-socialist system to the health transition of the population has contributed to high premature mortality from avoidable causes [109; 39; 40].

Persisting geographical and social inequalities in health are also a source of concern in Hungary. For instance, the gap in life expectancy at birth between counties with the highest and lowest levels was 6.7 years for men and 4.3 years for women in 2000 [110]. The difference is partly attributable to the presence of disadvantaged population groups, especially the Roma minority, whose health is substantially worse than that of their ethnic Hungarian neighbours [111].

Hence, the challenges facing the Hungarian health care system are complex, an aging population coupled with high rate of premature death (and consequently of preceding illness), unequally distributed within the population, a situation that is partly attributable to the failures of the system itself.

2.2. Overview of the Hungarian health care system

The current structure of the Hungarian health care system represents a considerable departure from the former, highly centralized, state-socialist model. Since 1989 the system has become more pluralist with responsibilities divided between various players, while the previous hierarchical relationships have partly been replaced by contractual relationships and quasi-public arrangements.

Figure 2.2. Organizational structure of the Hungarian health care system, 2001

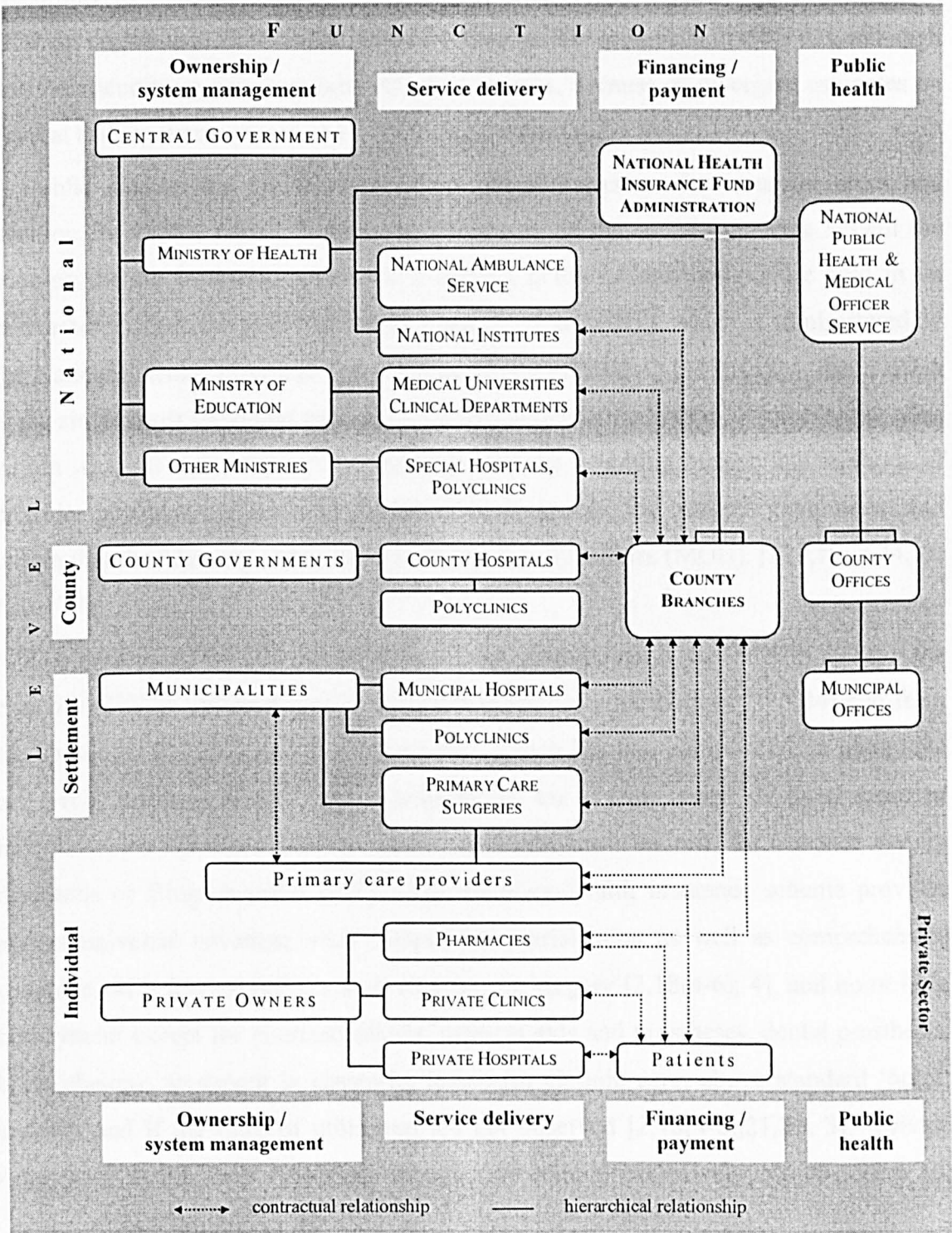


Figure 2.2 presents the current organizational structure of the health care system according to the three levels of public administration and three main functions, governance (stewardship), financing and service delivery. The new system is based on contracts, in which purchasing and service delivery are separated, although the current Hungarian health care system is still predominantly publicly financed and provided.

2.2.1. FINANCING

According to statistics supplied to international agencies, Hungary spent 6.7% of its GDP on health care, 75.5% of which came from public sources in 2000 [107], although health expenditures data vary with different sources, because of divergent estimates on general and local tax sources and informal payments [112-116].

Public sources are chiefly compulsory social insurance for recurrent costs and taxation for capital costs. Within the framework of the social insurance system the statutory health insurance scheme is a distinct entity. Contributions are held in an earmarked budget, the so-called Health Insurance Fund (HIF), which is administered by the National Health Insurance Fund Administration (NHIFA) [117; 118]. The NHIFA is the single most important monopsonistic purchaser in the system. However the rules within which it acts, such as contribution levels, its operating budget, and methods of provider payment, are made by the National Assembly, the national government and within that the Ministry of Health, Social and Family Affairs (MOH). [119,19; 2,34,35; 120-122]

The revenue of the HIF comes from a proportional payroll tax (14% in 2002) – the employer (11%) and employee (3%) health insurance contributions [119,24] and from the so-called ‘hypothecated health care tax’, which has two components: a lump sum tax (HUF 4,500 in 2002)¹⁷ and a proportional tax (11%), levied on those types of income which are not subject to social insurance contributions, for instance certain dividends or fringe benefits [123]. The statutory health insurance scheme provides almost universal coverage, with compulsory participation as well as comprehensive coverage, with few exclusions, such as cosmetic surgery [2,18(4-6); 4], and no or little co-payment except for pharmaceuticals, medical aids and prostheses, dental prosthesis, balneotherapy, treatment in sanatoria, long-term chronic care, above standard ‘hotel’ services and if the rules of utilisation are not observed [2,18(4-6),21,23; 3]. Private sources of health care financing, though, are almost exclusively out-of-pocket for

¹⁷ €18.

informal payment and for services, which are either partially or fully excluded from cover by the HIF, as the private health insurance market is insignificant [124].

As a general rule the HIF covers only the recurrent costs of services. The owners of health care facilities, mainly local governments, are responsible for capital costs according to *Act CLIV of 1997 on Health* (the principle of 'maintenance obligation') [1,155(2)]. They are obliged to cover the capital costs of services, which usually come from general and local taxation. In addition, the central government offers substantial help via conditional and matching grants [125].

The HIF is divided into over twenty budget lines (sub-budgets) according to service types (such as family doctor services, dialysis and acute inpatient care), which are not devolved to the county level [e.g.126, Annex 1]. A national budget ceiling is set for most sub-budgets, and various payment methods are used to ensure that the budget is not exceeded [2,34; 127,22-30; 120]. Institutional providers are paid from the sub-budgets of the HIF according to the type of service provided. Outpatient specialist services are paid on a fee-for-service basis, using a point system (points for procedures), acute inpatient care is reimbursed using DRGs, and chronic care by patient days [2,34; 127,22-30; 120; 122]. Health workers are predominantly salaried public employees [128], with the exception of family doctors, most of whom contract with both the NHIFA and local governments and are paid on a capitation basis [46; 120,11(1),12(2)]. In 2000, health care workers were the fifth lowest paid among the full-time employees of the 14 main sectors of the Hungarian economy [12,4.12,p.90]. The situation was even worse when compared with the average salary of workers with higher education qualifications. The health sector ranked as the second worst paid among the other main sectors [12,4.16,p.96].

2.2.2. SERVICE DELIVERY

Local governments are the main service providers in the system, owning most health care facilities, including primary care surgeries, polyclinics and hospitals [43,107(1)c; 129]. Tasks are divided between municipalities, responsible for providing primary care, and county governments, responsible for specialist care for their resident population [43,8(4),70(b)], but if municipalities are willing and able to provide specialist in- and outpatient care, county governments have to transfer the ownership of health care facilities along with the responsibility for service provision, according to the principle of 'subsidiarity' [43,69(2-6)]. In general municipalities own independent, multi-speciality ambulatory institutions ('polyclinics', which provide outpatient specialist

care), single-specialty ambulatory institutions ('dispensaries', which provide outpatient care for chronic diseases), and multi-specialty municipal hospitals (which provide secondary acute and chronic, inpatient and outpatient care). County governments own large, multi-specialty county hospitals, which provide secondary and tertiary, acute and chronic, inpatient and outpatient care.

While local governments are responsible for making health services available for the local population, i.e. they have 'territorial supply obligation', they are allowed to contract out service delivery to private providers [1,155(2); 130]. Nevertheless, the private sector is small except for primary care, whereas most family doctors work as independent entrepreneurs, although their surgeries and equipment are owned and made available for them by local governments (a scheme known as 'functional privatisation'). Service providers, whether public or private, have to contract with the NHIFA to become eligible for HIF funding [2,30-33,36-38; 131,13-25].

The national government is responsible for the provision of certain special services, including for instance public health (via the National Public Health and Medical Officer Service), emergency ambulance services and blood supply [1,35-74,94-96,223-227,142(2)], and it still owns a limited number of special hospitals, including national institutes of health, university medical schools, sectoral services and sanatoria [e.g.132].

2.2.3. GOVERNANCE AND OTHER ROLES OF THE NATIONAL GOVERNMENT

The national government is the dominant regulator of health services, exercises statutory supervision over the HIF and controls the NHIFA [133-135; 121], covers the deficit of the HIF [119,3(2)], pays premiums in respect of non-contributing groups [119,39(1),16(1)b-o; 123], provides capital funds [125], finances and delivers public health services and provides most tertiary care services, mainly through the MOH [1]. The government also finances health education, research and development, and co-payments that would otherwise be paid by the poor [136-138].

Despite early decentralisation measures, the national government has retained a central role in resource allocation decisions within the health sector. All aspects of the purchasing function have been centralised, and health care capacities are addressed through the contracting process [139]. Although the national government does not directly determine the inputs or outputs of the health sector, it regulates all aspects of the production process, including human resources [140; 141], pharmaceuticals, medical devices and health care facilities, which fall under registration and licensing systems [142-148] and price regulations apply to publicly employed health workers,

pharmaceuticals and medical aids and prosthesis. Further, patient rights are regulated extensively in the *Act CLIV of 1997 on Health* [1,6-25,28-34; 149-151].

2.3. Evolution of the health care system

The evolution of the Hungarian health care system in the 20th century can roughly be divided into three main periods. Before World War II both the financing and the delivery of health services were characterised by a public private mix, with health insurance gaining ground rapidly and increasing state involvement in the Bismarckian model [66; 152,pp.31,37; 153]. Physicians could be in private practice or be employees of public or private insurance companies or hospitals, but frequently they combined these options [49,pp.36-37; 154; 73].

This development was disrupted at the end of World War II, when the integrated state-socialist model of health care systems was established [153]. The state assumed virtually exclusive responsibility for both the financing and delivery of health services, including hospitals, polyclinics and the district doctor services [155; 156], with no private insurance, while private practice was permitted only on a part time basis [157,39(2)b]. The system promised comprehensive, high quality care free of charge to each citizen, but an increasing gap had developed between rhetoric and reality [40; 39; 153]. Health services were regarded as an unproductive sector of the economy, with low priority in resource allocation decisions [70], and health workers, especially physicians, were kept on a low salary [50; 49; 8; 67].

The system was unable to respond adequately to the revolution in medical technology and the health transition of the population, when non-communicable diseases began to dominate mortality [158; 40]. It reacted to the changing needs by the inflation of input targets, which led to the development of excess capacities, whilst patients wanted not more, but better care [52]. Tensions were further aggravated by the influence of politics on the budget setting process, which created regional inequalities in service provision, as well as inequalities in terms of medical specialities [40; 159; 71; 153; 39]. As a result, a crisis had gradually developed, which was characterized by excess capacity and deteriorating service quality, a mixture of waste and shortages, inefficiency and unequal access [39; 52; 153].

The need for radical health care reforms became increasingly apparent in the 1980s, coinciding with signs of incipient collapse of the centralised economic and political system. Major health care reform has been on the policy agenda ever since.

2.4. Health care reforms¹⁸

Major health care reforms in Hungary began in the mid 1980s, when the continuously deepening recession of the economy and the increasing pressure from the emerging political opposition allowed a reform-oriented, liberal faction of the communist party to take control of government and formulate policies for the reform of the health care system. In the first phase of the reform, until 1994, most reform measures were implemented as originally devised during the reform communist period, with considerable decentralization. All this happened in the context of the transformation of the economy, which was characterized by a deep economic recession. Although GDP began to recover in 1994, the state budget deficit prompted restrictive measures. The second phase of the reform was overwhelmed by the economic stabilization efforts of the government of 1994-1998, and the goal of cost-containment began to dominate health care policy. Despite the favourable economic climate characterized by impressive and stable economic growth, cost-containment remained the main policy objective throughout the period of the government of 1998-2002.

The reform measures implemented so far reflect the disparity between objectives pursued before and after 1994. Before 1994, health sector reform was characterized by decentralization and by the end of 1994 the new contract model of health services was operating. The emphasis was placed on incentives (e.g. payment methods) to produce the necessary structural changes without direct government intervention. After 1994, cost-containment became the utmost priority of government policy. The HIF was increasingly seen as a potential threat to fiscal balance and efforts were made to restore government control to allow fiscal restrictions and direct intervention in the system.

2.4.1. THE BLUEPRINT FOR HEALTH CARE REFORM: THE REFORM COMMUNIST ERA (SECOND HALF OF THE 1980S)

During the second half of the 1980s, the Ministry of Social Affairs and Health established the so-called 'Reform Secretariat' in 1988, which produced policy proposals on the basis of international experiences [36; 41]. The Ministry launched a number of pilot projects, including the adaptation of the American DRG-based hospital payment system, and successfully implemented some early changes, including the shift from tax-based financing to compulsory social insurance in 1989 [42], and the legalization of private health care provision [44; 45].

¹⁸ This section is a summary of the Health Care Systems in Transition country profile for Hungary, currently being published (Gaál P: Health Care Systems in Transition: Hungary [29]).

2.4.2. IMPLEMENTED AS PLANNED (1990-1994)

The first freely elected government continued the major structural reforms according to previous plans. The *1990 Local Government Act* created the provider side of the new contract model [26; 43]. The ownership of primary care surgeries, polyclinics and hospitals was devolved from national to local government along with the 'territorial supply obligation' [43,107(1)c,8(4),70(b); 129,132(1)]. The new owners became responsible for maintenance and investment costs, but central government established the system of 'earmarked and target subsidies' to support local governments with conditional and matching grants [125].

Policies to strengthen primary care were implemented gradually. In 1991 the National Institute of Family Medicine was established [160]. In 1992 district physicians were renamed 'family physicians', postgraduate training for general practitioners was made compulsory, and undergraduate training in family medicine for medical students was introduced [161; 162]. People were allowed to choose their family physician [161], and the system of capitation payment with contracting of family doctor services was introduced [46]. Family doctors were encouraged to become private and contract with local government, with surgeries and equipment still owned by the local government ('functional privatization'). Real (ownership) privatization was significant only in the pharmaceutical sector, where the majority of manufacturers, wholesalers and retailers were sold off and the market was liberalised.

In 1993 new provider payments mechanisms were introduced for specialist services (fee-for-service points, i.e. points for procedures, DRGs and patient days) with the cost-containment mechanism of capping the sub-budgets of the HIF [47; 163; 122]. No real change happened, however, in the remuneration of the health workforce. The act of public employment guaranteed a minimum salary, and although no upper ceiling was determined, salaries remained low in comparison to other sectors [128; 17; 23,4.12,4.16].

At the end of 1993, parliament created a legal framework for the establishment of non-profit health insurance on a complementary basis [164], and in 1994 the Hungarian Medical Chamber and the Hungarian Chamber of Pharmacists began to operate on a self-regulatory basis, with compulsory membership for practising doctors and pharmacists [165; 166].

By the end of the first governmental period post-transition, the foundations of the new model of the Hungarian health care system had been laid down. There was a single

monopsonistic purchaser, the NHIFA, which contracted with service providers, mainly in the public but also in a growing private sector with family doctor services and pharmacies. The supervision of the HIF and the control of the purchaser were delegated to a quasi-public body, the Health Insurance Self Government, but most purchasing decisions were made by the national government and the National Assembly. The transition of the economy was well under way, and began to show signs of recovery in 1994. In 1994, the successor of the communist party was voted back to power [167].

2.4.3. THE BEGINNING OF COST CONTAINMENT (1994-1998)

The first significant measure taken by the new government in June 1995 was not favourable for the health sector. The government had anticipated an economic crisis (see Table 1.2, Figure 1.3) and in the middle of 1995 introduced an economic stabilization package, which targeted the welfare provisions of the state [168; 169]. The health care budget was cut in two consecutive years [170; 171], along with some restrictions in the benefit package, such as the exclusion of dental care and occupational health services [168,80,92; 169; 172].

The government decided to tackle directly the oversized hospital sector by determining the upper limit of capacities the NHIFA could contract for [170,10(2); 139,8-9]. As a result, approximately 18,000 beds were removed from the system between 1995 and 1997 [35,1.5; 173,8.1].

The government also had a revenue-side strategy to mitigate the evasion and avoidance of social insurance contributions. The social insurance contribution base was widened, the employers' health insurance contribution rate was decreased, and a lump sum tax (the 'hypothecated health care tax') was introduced in 1996 [174,10; 175].

The other main policy thrust was to target the Health Insurance Self Government, since the government considered its extensive power over budgetary decisions as a potential threat to the proposed budget cuts. Thus it curtailed these rights in 1996 [176; 177], decreased the number of representatives, and made members no longer elected, but delegated [178].

In summary, the government implemented a strict cost-containment policy, which resulted in a significant cut in the health care budget. By the end of 1997 health care expenditures were almost 30% lower in real terms than in 1990 while, in the same year the GDP increased by 4.6% (Table A1.4 in Appendix A.1 and Table 1.2). However preoccupation with economic stabilization left little time to think about the future of the health care system. Although a regional modernization project was launched, and the

Ministry of Finance prepared a proposal, which envisaged financing reform by introducing competition between insurance funds [179], the government had no time left to put the idea into practice, since the 1998 elections brought the opposition parties into power [167].

2.4.4. SEARCHING FOR THE WAY FORWARD (1998-2002)

One of the first measures of the new government was to abolish the residual autonomy of the social insurance funds, thereby taking full control over the HIF and the NHIFA [133; 134]. The Secretariat for the Supervision of the Social Insurance Funds of the Prime Minister's Office proposed a model of competing health insurance funds, but the MOH opposed the idea. Eventually, after a year-long debate, the Prime Minister dropped the plan for insurance competition and shifted the supervision and control of the NHIFA to the Ministry of Finance [135], the MOH regained its primacy in policy-making, and the policy focus was shifted to the delivery system, but within a context characterized by persistent efforts of the government to contain overall health expenditure.

The government targeted both the revenue and the expenditure side of the HIF. The hypothecated health care tax was extended and increased substantially [123], while the health insurance contribution was decreased from 18 to 14% [180], and later on the upper ceiling of the employee contribution was abolished [181]. The expenditure side was more problematic, since there was no easy way to cap the pharmaceutical budget as had been done with other budget lines of the HIF. Nevertheless, the government kept a close eye on the pharmaceutical budget and implemented a number of rationalization measures, including the revision of the subsidy system and the decrease of wholesale and retail price margins of expensive medicines [126,4(1)d,5(3); 182-184].

The first delivery side reform measure by the MOH came in the beginning of 2000, when the 'practice right' was introduced with the original objective to create a market for family doctor practices [185; 186]. The government offered subsidized loans for family doctors to help them buy their surgery and equipment from local government [186]. The reform continued with establishment of the 'freelance' physician status, and encouragement of the corporatization of public providers in 2001 [130].

The effect of the new legislation at the end of 2001 and the first measures of the current government, which was formed by the previous opposition parties after their election victory in 2002, on informal payment has yet to be seen, but as indicated by the response of the former minister of health to a parliamentary question, expectations are

high that these measures will ultimately eliminate informal payment from the system. Nevertheless, it is conspicuous from the above summary of health care reform in Hungary that there have been no attempts to tackle the problem directly. Indeed, as the following brief summary of the history of informal payment will show, the ambiguity concerning the nature of the problem has had profound effect on policy making and implementation, ever since informal payment got onto the agenda [50; 67]. (Appendix E provides a more detailed discussion of the history of informal payments.)

2.5. The history of informal payment

According to Ádám [50; 49,pp.56-61], informal payment was an unknown phenomenon before World War II. He argued that the spreading of informal payment as a problem was first mentioned in the autumn of 1948 and it subsequently occupied a key position in the health policy agenda. The official party policy distinguished between gratitude payments ('thank you' payments that are given voluntarily after the service) and other, corrupt forms of informal payments (e.g. cheating with sickness benefit), which in fact meant the toleration of the phenomenon [49,pp.62-213]. Legal actions against gratitude payments were ruled out and physicians in specialties, where informal payment was rare or non-existent received higher salaries.

The reform communist era has brought no change in this respect, except for that in 1988, just before the political changes, the government decided to tax gratitude payment on the basis of the declaration made by the tax payer in the tax returns [187; 188,17(7); 8,pp.58-91]. The taxation policy is examined in somewhat more details in chapter 5.

Since then, no further direct governmental intervention has been proposed to tackle the issue. National health policies in the new reform era are remarkably consistent in how they view informal payments [189]. The phenomenon is undesirable, but its elimination can be envisaged only in the long term, with the exclusive use of indirect measures [37; 38,p.190]. Although in 1998 the new minister of health convened an expert committee to propose solutions for informal payments, the report of the so-called 'Gratitude Payment Committee' had no visible effect on policy making. This is not surprising, however, as the academic debate has long been characterised by much polemic.

In Hungary scientific research on informal payment dates back to the 1970s, initially with the aim of supporting official policies. Empirical research papers in the official journal of the MOH [e.g.77; 78; 82; 190; 80], were accompanied by articles on medical

ethics, which echoed the official policy of separating the corrupt and non-corrupt forms of informal payment on the basis of the cultural origin of the phenomenon [e.g.191; 192-194].

In parallel with the softening political climate in the 1980s, a second wave of academic debates enriched the discussion with approaches that explicitly criticised the system [85; 195; 65; 196; 70; 66; 197]¹⁹, and the intensive debates received a new push at the beginning of the 1990s when expectations of reforms were articulated [e.g.202; 64; 71; and subsequent discussion in Replika 63; 9; 52; 69; 203; 153], but the nature of informal payment remained contentious with confronting views on the desirable policy measures to address the phenomenon [e.g.39; and 63; vs. 68; or 52; vs. 69].

2.6. Conclusions

Hungarian health care reforms in the 1990s have sought answers to the crisis of the state-socialist health care system, in the context of massive political, social and economic changes. Early structural reforms have established the new contract model of health services and introduced incentives for efficiency via output based provider payment methods.

The system is contract-based, with purchasing (NHIFA) and service delivery (providers, owned mainly by local governments), as well as responsibility for service provision and service delivery are separated. Despite large scale decentralization measures and privatization efforts, the Hungarian health care system is still predominantly publicly financed and provided. Nevertheless, further reform efforts were overwhelmed by strict cost-containment policies, which were characterized by centralization and direct government interventions.

The most important challenges the Hungarian health care system faces are the disappointing health status of the Hungarian people, and the continuous financial pressure, despite the fast and stable economic growth of the past 5 years. After 15 years of continuous reform, the health sector is still struggling with the legacy of the state-socialist system, which informal payment has remained integral part of.

Health care reforms of the past 15 years have created a new health care system, but were unable to cope with informal payment. Building on the concept of gratitude, the idea of 'separate treatment' and 'no direct action' has dominated policy making ever

¹⁹ For empirical research in this period see for instance Bánlaky et al. [198] Antal [199; 159], Szabó [83], Ékes [200], Dobossy et al. [79], Hungarian Central Statistical Office [201].

since informal payment emerged in the Hungarian health care system. The reluctance of politicians to act more directly and explicitly is not, however, surprising since the role and nature of informal payment has always been contentious, with academic debates characterised by much polemic.

CHAPTER 3.

3. THEORIES OF INFORMAL PAYMENT

Chapter 2 provided background information for the study. Reviewing the changes of the past 15 years and the history of informal payments we have concluded that recent health care reforms were unable to cope with informal payments. The reluctance of politicians to address the phenomenon explicitly is not surprising though, since the nature of informal payment has always been subject to intensive debate. This study steps back from this debate to examine the theoretical basis for understanding the persistence of informal payment in the Hungarian health care system, to review the available empirical evidence, and to generate new pieces of evidence to finding an answer to the key question facing policy makers: 'why do patients give?'

This chapter proceeds by exploring the theories of informal payments. First, the available definitions of the phenomenon are examined and a new definition is proposed, which identifies the additional nature of payments beyond what is defined by the concept of entitlement as the key distinguishing feature between formal and informal direct contributions. Then, we summarise the arguments in the theoretical debate about informal payment in Hungary in terms of the causes of the phenomenon, the motivation of patients and doctors, and its impact on health system performance. The essence of the debates is distilled in two contrasting hypotheses of informal payment. Finally, the limitations of existing theories are considered and a new cognitive-behavioural model of informal payments is proposed, which builds on the economic explanation of the phenomenon, the theory of government failure, Hirschman's theory of behavioural responses to decline in organizations [106] and allows for the peculiarities of the health sector.

3.1. The definition of informal payment

So far we have talked about informal payment without discussing what precisely informal payment is. Unfortunately, there is no generally accepted definition of informal payments [96], so it is necessary to look at the issue in more depth. Drawing on not just the Hungarian, but the broader, international literature, this section highlights the main definitional issues, while Appendix F elaborates on the case for a new definition.

The international literature contains at least as much controversy as seen in the debates in Hungary. Even the terms used to denote the phenomenon vary greatly:

gratuities or gratitude payments [67], envelope payments [204], under-the-counter payments [74], unofficial payments [103], under-the-table payments [101] to name but a few. More importantly, the proposed definitions either reflect certain assumptions on the nature of the phenomenon (why patients give, is it good or bad), which are not necessary true in all cases, or are inconsistent, i.e. they are not able to separate informal payments from other ('formal') payments, so that the same phenomenon is consistently included or excluded across all countries and within a particular country over time. Furthermore, an appropriate definition should be broad enough to capture the diversity of the phenomenon, i.e. it should include all observed variants of informal payments.

Indeed, informal payments have shown to be heterogeneous with many faces, from sweets and flowers to goods and services, which should be part of the service, but which patients must provide for themselves, such as nursing, meals, bedding, clean laundry, medical supplies, pharmaceuticals and even diagnostic tests, from *"brick payments"* (patients and relatives are invited to buy a token brick for a certain sum, by which means they supported the health care institution) to *"advance payments"* (which are made by patients to specialists in their private surgery, not for the private visit, but to gain subsequent admission to a public hospital), from small tips to enormous amounts for a single operation [104; 102; 96; 101; 103; 95]. Another classic example is the so-called *"gratuities"* or *"gratitude payments"*, defined as patients thanking physicians for their services entirely voluntarily after the treatment, a phenomenon often thought to have deep cultural roots [67; 96,pp.3,10; 104,pp.4,10,17,21].

3.1.1. INFORMALITY, ILLEGALITY, CORRUPTION?

The proposed definitions in the literature generally view informal payment as a public sector phenomenon and are based on four distinctive characteristics that separate it from other, related phenomena: informality [189; 102], illegality [Chawla, 2000 cited in 104; 102], corruption [96] and voluntariness [67]. We argue that none of the distinctive features implied by these definitions are able to provide a consistent basis to discriminate between informal payments and other phenomena.

First, illegality is not a good criterion, because the legal assessment of the various forms of the phenomenon, i.e. whether or not they contravene the established laws and regulations, differs not just between countries, but even within a particular country over time. For instance, in his historical analysis, Ádám [49,pp.83,93-95] shows how all forms of informal payments made to doctors became illegal in Hungary once physicians became civil servants during the nationalisation process implemented by the communist

regime in the 1950s. In contrast, since 1989, the income from informal payments must be reported in tax returns [8]. Or to provide another example, informal payments paid to physicians and other health workers ("*envelope payments*") may be illegal in Poland [Chawla, 2000 cited in 104], 'brick payments' are certainly not.

Second, these two examples are good illustration of the point that informality is not a good defining criterion either, while another example is the aforementioned advance payments, reported by Shahriari et al. [104] in Poland. If the private practitioner reports these payments to the tax authorities as part of his or her income, they become 'formal', although advance payments are informal in that they are paid to gain admission to a public hospital that levies no formal charges. Furthermore, there are certain payments, not registered by the state, but excluded by researchers from the phenomenon. For instance, voluntary purchases from private providers are not, in essence, informal payments [96,p.1], even if these are informal in the sense that they are not accounted for by the provider to avoid paying tax. One could argue, however, that if not all unregistered payments are informal payments and not all forms of informal payments are informal in the sense that they are unreported and unaudited, the usage of the term 'informal payment' creates confusion. We acknowledge this problem, but recognise that there is an emerging consensus in favour of this approach amongst researchers [97; 205; 102; 104; 93; 95].

Third, we should discuss the identification of informal payments with corruption, and the idea of differentiation between payments that are discretionary as opposed to what is required [67; 96,p.1; 104,p.10]. One contradiction of this approach is that while Lewis and Shahriari suggest that only payments where there is some degree of coercion from the provider side (which they exercise to further their own interests at the expense of the public interest), should be considered informal[96,p.4], Ádám's definition implies the opposite. Furthermore, there are a number of examples of informal payments that are difficult to fit into the framework of corruption, for instance in-kind contributions. Even Shahriari et al [104,p.10] acknowledge that "*there is a difference between payments from which providers directly benefit, and those that reflect... the dire financial situation of the institution*", and refer to the example of bringing one's own clean linen and food during hospital stays. Examples from many developing and transitional countries [96; 103], however, identify a more fundamental problem with the corruption framework. In countries where salaries of health workers have not only plummeted, but non-payment is also common, the alternative to informal charging is leaving one's job, which would result in the total collapse of the system. We argue that

stigmatising patients and health workers as corrupt in these extreme circumstances is absurd. Patients and doctors simply adapted to the rules of the game. But if informal payments are not always corrupt, illegal, and not even informal then what is the characteristic that is common to all forms of informal payments described so far?

3.1.2. ENTITLEMENTS: AN ALTERNATIVE DEFINITION OF INFORMAL PAYMENT

We argue that all forms of informal payments involve some form of direct contribution by patients or their households in addition to what is formally required, i.e. what the legally defined terms of entitlement determine. These describe those services that can be utilized by patients, what these services comprise and how much out-of-pocket payment has to be paid. “Legally defined” does not necessarily mean that entitlements to health services are regulated in detail by law. Entitlements can be defined by several actors in the health care system, for instance private providers or insurance companies.

Hence, informal payments are a subset of out-of-pocket contributions, the distinguishing characteristic being that formal out-of-pocket payments are stipulated in the terms of entitlements, whilst informal payments are made in addition to them. Accordingly, informal payment for health care can be defined more precisely as:

‘a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or those acting on behalf of patients, to health care providers for services which the patients are entitled to’.

It is important to note, however, that the boundaries of informal payments set by this definition imply a number of inclusions and exclusions, such as voluntary purchases from private providers, which are not accounted for by the provider to avoid paying tax. In contrast, our definition does not exclude informal payments in the private sector. In principle, it is possible that patients pay more to a private provider than the predetermined fee, even if there is no obvious reason why they would do so. Further, our definition does exclude a number of informal activities, such as forcing patients to go to private practice, pilfering of drug supplies, misuse of formal revenues or rarely showing up during official working hours [98], which are not informal payments, nonetheless they can have similar implications to informal payment for policy making. Finally, our definition deliberately ignores the motivation of the actors and the timing of the transaction, and therefore it does not exclude gratuities. We argue that while it is possible to argue a case against the validity of the gratitude payment concept on a theoretical basis, for instance whether before and after can be meaningfully separated in health care, or that whether gift giving can be envisaged as a unilateral act, or that there

is a correlation between the extent of financial hardship and the various forms of informal payment, this remains a question that should be explored by empirical research. It is rarely sufficient to conclude whether a gift was given voluntarily or was (in its wider sense) coerced from knowledge of what is given, when and to whom. Empirical research on this issue should address the motivation of actors, which remains a key distinguishing characteristic of 'true' gratuities.

It must be noted, however, that while the proposed definition seems to be consistent with the experiences of former communist (CCE and FSU) countries, it may not be applicable to Western European countries and Australia. One such phenomenon, whose informal payment nature is debated is the extra-billing practices of French physicians. In the French system there are two groups of physicians, Sector I and Sector II [206]. Sector I physicians are reimbursed according to a fee schedule and agree not to bill for additional amounts, so if a Sector I physician charges extra, that would be considered an informal payment according to the proposed definition. On the other hand, an extra fee, charged by Sector II physicians is not informal payment, since they do not subscribe for the fee schedule, they do not agree not to charge extra, i.e. physicians in the French system are allowed to choose whether they would like, at least partly, to determine the terms of entitlement. One may argue, however, that this distinction is not relevant, since these practices are in general not considered akin to the practices of physicians in CEE and FSU countries. While we think that informal payments are a more general phenomenon that is not exclusive to former communist countries, the relevance of our definition to more developed countries has to be explored further.

3.1.3. IMPLICATIONS FOR RESEARCH: OPERATIONALISATION OF INFORMAL PAYMENT

Whilst the above conceptualisation of informal payment provides a starting point for its study even in an international context, it is not obvious how to put the definition into practice. The difficulty of operationalisation relates to the problems of obtaining appropriate data that will permit separation of formal and informal payments, as well as of the various forms of the phenomenon.

The complexity of the task of separating formal and informal payments reflects the difficulty in assessing whether entitlements are clear to the various actors, and to what extent formal and informal payments coexist in the same system, in particular for the same service. There are two possible ways to operationalise informal payments. First, patients can be asked directly to distinguish formal and informal payments. Second, it

is possible to ask respondents how much they spent (contributed) according to different type of services and different type of providers, and then researchers have to 'distill out' informal payments on the basis of total out-of-pocket payments reported and of the knowledge of existing formal direct payments determined by the laws and regulations in the health care system under study.

If entitlements, including the level of co-payments, are laid down centrally and apply equally to all health care providers, the indirect method can work well, while as systems increasingly decentralize decisions about terms of entitlement, researchers increasingly rely on patients to separate the formal from the informal, since it is increasingly difficult to distinguish informal payment when formal co-payments are widespread and individual providers are allowed to set them freely. However, if patients are asked directly, their perception of what constitutes an informal payment may be different. Furthermore, the direct method assumes that patients know what they are entitled to, but evidence has shown that patients are often confused about their health entitlements [96,p.16; 102; 104,p.10].

Further difficulties arise when it comes to the separation of the various forms of informal payments. The distinction between in-kind contributions and cash payments is not straightforward as certain in-kind contributions, such as pharmaceuticals, may need to be paid for, even if ultimately they are provided in-kind. More importantly, as discussed before, gratitude payments are not easy to distinguish, and quantitative methods alone may be insufficient to capture the motivation of the actors. As Lewis [96,p.14] argues, qualitative methods are important to explore motivation, which is difficult to assess in surveys.

In conclusion, there seems no unambiguously ideal way to operationalise the concept of informal payments, as important aspects of formality or informality, legality or illegality, terms of entitlement and the existence of formal out-of-pocket payments vary between countries. Nonetheless, conceptualisation in a way that makes it possible to incorporate the findings of existing empirical studies is the first step towards understanding informal payments and so providing an empirical basis for new effective policies to tackle the phenomenon.

The proposed new definition suggests that the essence of informal payment is that patients pay more than is required by the terms of entitlement. So, the question arises: why do they do so? From the policy perspective knowledge of the causes of informal payment and the motivation of the actors is important, not just because it helps to decide

what to do about it, but whether it is necessary to do anything at all. Different causes imply different consequences for the performance of the health care system and, as we have argued in chapter 1, whether informal payment is source of policy concern ultimately depends on how it prevents the system to deliver the desired health policy objectives. The next section addresses exactly these issues in more detail.

3.2. Why pay informally for health care? The theoretical debate

This section discusses the theories of informal payment on the basis of the Hungarian theoretical literature. Although the available literature is fairly extensive, little is published in English. In contrast, the English language literature is still limited, despite growing international interest in the issue [74; 101; 99; 98; 96; 102; 104; 103; 97; 95; 94]. Whilst the Hungarian debate may not be relevant in all settings, accounts of other countries' experiences, such as Bulgaria, Poland and to a certain extent even countries of the FSU, show a remarkable similarity of arguments and threads of discussion [74; 104; 105; 96]. Beside the review of the Hungarian theoretical debates we use some elements of the previous section, drawn from a wider international literature.

3.3. Theories of the origin of informal payments

The causes and origin of informal payments have long been debated in Hungary. Researchers have advanced at least 13 different casual factors, singly or in combination with others, which we have grouped in three main categories: social-cultural, legal-ethical and economic. These were put forward in two major waves.

During the 1970s the theoretical discussion was dominated by the social-cultural and ethical explanations of informal payment. These theories provided scientific underpinnings for the official policy, which did not acknowledge that informal payments had anything to do with the construct and operation of the Semashko system itself. During the 1980s, however, the regime had increasingly permitted the publication of critical views, which introduced the legal and economic explanations into the dispute. These causal factors explicitly linked informal payments to the failures of the health care system, or openly criticised the official policy of 'no direct action'. This section provides a brief summary of these explanations. An extended discussion is in Appendix G.

The earliest explanations considered informal payment a custom rooted in the culture of society. As Szabó [72, p.285] put it: *"We must accept that tipping and presentation*

existed in the past and will be with us in the future for a long time, too. It is impossible to forbid people to give gifts". The proponents of this 'gift giving' or 'gratitude payment' approach argued that healing traditionally creates a sense of gratitude that patients express in the form of gifts. Being embedded in national culture, the origin of informal payment predates the establishment of the state-socialist 'Semashko' system, thus it is difficult, if not impossible to change.

In contrast, economic explanations argue for causes rooted in the design and operation of the 'Semashko' system that eventually lead to shortage, the immediate cause of informal payment. The first economic interpretation was introduced into the theoretical debate only in 1983 as the regime increasingly permitted the publication of critical voices. Petschnig [85] identified the 'freeness' of health services and the resulting excess demand as the cause of informal payments, which was later extended with other arguments, including that the system restricted the sovereignty of consumers by denying free choice of provider [70], the defencelessness of patients [109], the fear and anxiety that accompany medical interventions [71], and the sudden increase in the demand for health services as a result of nationalisation of the health sector after World War II [49]. Nonetheless, these demand side arguments still did not imply a fundamental problem with the delivery of health care. The first supply side criticism came from Kuti [70], who argued that increased demand could have been satisfied if investments in health care had been given priority, but the macroeconomic policy of the communist regime did not favour this "*unproductive*" sector of the economy. She argued that low salaries of health workers could also contribute to inadequate supply either by making them withhold performance or forcing them to moonlight, whilst Bordás [52] saw inappropriate provider payment methods as a key cause of informal payments.

Finally, the legal-ethical approaches emphasized a different aspect: how internal (professional ethics) and external (legal sanctions) norms and controls gave rise to and facilitated the spreading of informal payments. At the centre of the ethical explanation is the 'greedy physician', who abuses his power to extract money from patients [192], whilst the legal explanation sees ambiguous regulations and weak enforcement as the cause of informal payments taking roots in the system [66; 65].

In summary, the various theories concerning the causes of informal payment can be classified into three main groups, each of which has markedly different implications for policy responses. The cultural explanation assumes a never ending struggle with few or no effective tools in the hand of policy makers, whilst the economic and legal-ethical

explanations offer feasible responses within a reasonable time period, even if the implied policy measures are different. Policy on informal payment, however, should not only focus on whether informal payment can be eliminated, but also whether it should be. Has the phenomenon any undesirable consequences for patient care? If not, why bother? The policy relevance of informal payment depends on its impact on system performance, a matter that has also been the subject of intensive debate. The following sections review the main elements of this debate.

3.4.

**Impact of informal payment on the performance of health care:
the theoretical debate continued**

The theoretical discussion on the impact of informal payment on system performance has been taking place at two levels. First, at the level of the individual transaction, it has been asked how the actual service received differs between paying and non-paying patients. Second, there is no agreement on how informal payment influences the functioning of the health sector at the system level in terms of the allocation of resources and the distribution of income. In general, opinions were polarised between those, such as Balázs [64] and Orosz [39], who emphasised the central role of informal payment in allowing the system to function, and others, such as Blasszauer [65], Ádám [49] and Lengyel [68], who saw its undesirable consequences outweighing any positive effect.

3.4.1.

CONSEQUENCES AT THE LEVEL OF PATIENT-DOCTOR ENCOUNTERS

In line with the main causal hypotheses, writers on informal payment saw its impact on service provision lying between two extremes. Advocates of the social-cultural explanation argued that patients who paid typically received exactly the same quality of care as those who did not pay. In contrast, proponents of economic explanations assumed that, as a general rule, informal payment did yield better quality of care for the paying patients. To what extent, and whether this was true in all cases was disputed. The arguments did not just distinguish between clinical and service quality, but raised the question of what was the point of reference and even the possibility that paying patients could be worse off.

Kuti [70] and Bondár [63] argued that the standard could be lowered artificially, thus a 'better' service simply meant a return to the original standard. Kuti [70] also believed that paying patients usually received the same service, but with a better 'wrapping', i.e. informal payment influenced how physicians and nurses behaved with patients, their

kindness and attention, rather than the quality of the intervention per se. On the other hand, Petschnig [85] argued that paying patients could receive worse care insofar as appropriate referral was delayed because of the physician's fear of loosing informal payments. This argument was elaborated by Antal [153] and Csaba [69], who argued that paying patients might be disadvantaged if payment motivated physicians to provide otherwise unnecessary services. They noted the international evidence for supplier induced demand resulting from information asymmetry between patients and physicians (principal-agent relationship), with far reaching consequences for theoretical speculation about the impact of informal payment on patient care. Even if the primary motivation of patients is to obtain good quality services, physicians are able to manipulate not just the supply of services, as argued by Kuti [70] and Bondár [63], but the wants of the patients, manifested in supplier induced demand [71; 69]. Consequently paying patients cannot be certain whether they get what they would demand if they had the same knowledge as physicians.

On the other hand, citing Ellis and McGuire, Csaba [69] suggested that the response of physicians to incentives embedded in the payment system was limited by, for example, professional, ethical and legal sanctions. He argued that the concept of 'sense of duty' in the medical profession assumed that the welfare of the patient was not indifferent to the physician's own utility, which implied that there were limits to the extent to which they were willing to provide more services than necessary, even if incentives drove them to do so. This applies not just to over-treatment, resulting from supplier-induced demand, but to under-treatment (supplier-reduced demand).

Conversely, Bondár [63] argued that informal payment did motivate physicians to provide services in inappropriate circumstances, for instance with obsolete equipment or reused disposables, that they would not have done had there been no such incentive in the system. She argued that this was an important element in the sustainability of the state-socialist health care system. She also called attention to the diversity of health services, suggesting the need to adopt different explanations in different circumstances. For instance, in emergencies it is difficult to imagine how one might pay for better services in advance or how physicians could manipulate clinical quality in order to elicit informal payment.

3.4.2. IMPACT OF INFORMAL PAYMENTS AT THE SYSTEM LEVEL

So what are the implications of these hypotheses for the performance of the health care system? The underlying difference between the cultural and the economic explanations

is that the cultural explanation suggests no impact on the demand for and supply of health services, whilst the advocates of the economic explanations see informal payment as influencing the distribution of services and resource allocation. They did not agree, however, whether it acted as a co-payment, which affected the demand side only, or a real price mechanism, which led to changes in supply.

The earlier theorists, such as Petschnig [85] and Kuti [70] argued that informal payment were given directly to health workers it did not lead to an improvement in standards but just redistributed resources among patients according to their willingness to pay. As Kuti [70] put it "*...the money paid for a one-bed room does not contribute to other one-bed rooms being built in the hospital, instead it goes to weekend houses of senior consultants...*". In this respect it is not crucial whether paying patients received the same clinical quality in a better 'wrapping' (service quality), as argued by Kuti [70], a reversion to the original quality compared to an artificially lowered standard, argued by Bondár [63], or more, but unnecessary services (supplier-induced demand) as put forward by Csaba [69]. The common core of these arguments is that informal payment is merely a rationing mechanism, which redistributes the cost burden and the benefits of services within a given level of supply.

In contrast, Antal [71; 153] and Bondár [63] put forward the possibility that informal payment did influence the level of supply insofar as it contributed to the extension of capacities in those areas where the amount of informal payment was high enough to motivate doctors to lobby for more resources at the national level. Losoncz [109,p.192] reinforced this position by identifying the "*physician's proximity or remoteness to the distributive power*" as an important barrier to need-based resource allocation, whilst Buda [9] pointed out how subtle these bargaining mechanisms were. Moreover, Csaba [69] raised the possibility that these mechanisms could work the other way round, i.e. good connections might yield more resources, which in turn induce informal payment. These arguments, however, do not necessary imply more resources for the health sector, i.e. resource reallocation across sectors, just the reallocation of resources among specialities within the health sector, i.e. favouring one specialty at the expense of another.

The debate brought up another aspect of the impact on supply by informal payment, which was not the expansion of health services but rather prevention of a reduction in supply. Amongst others Bordás [52] argued that informal payment contributed to the ability to recruit physicians despite low salaries, whilst Bondár [63] pointed out the possibility that informal payment provided incentives for physicians to supply services

even if the infrastructure had deteriorated to otherwise unacceptable standards. These mechanisms were thought to contribute to the sustainability of the state-socialist health care system inasmuch as they kept the 'machine' running. In contrast, Kuti [70] emphasized the negative distributional impact of informal payment on the physicians' side. She argued that it was unevenly distributed among health workers and had too little connection to real performance to serve as a mechanism for complementing low salaries.

Whilst the primary question in relation to its system-wide consequences is whether informal payment solely acts as a redistributive process or whether it also influences resource allocation, the extent and nature of the redistribution is also important in terms of system performance. The mildest form is where only non-clinical elements of quality of care are redistributed from non-paying to paying patients, as suggested by Kuti [70], but clinical outcomes could also be involved in the 'reshuffle'. Antal [71] and Csaba [69] discussed the potentially worst case scenario, when both paying and non-paying patients were worse off, if non paying patients were 'under-treated', whilst paying patients were 'over-treated'. On the other hand, Kuti [70] argued that consideration of the distributional impact of informal payment on the cost of obtaining health care was as important as the distribution of benefits. She argued that informal payments were regressive, disproportionately affecting poorer people. Moreover, she argued, informal payment had become an unwritten law and the poor were least able to resist the resulting societal pressure. Unfortunately, she concluded, it was not possible to grant a formal exemption to something that was informal. In contrast, Galasi and Kertesi [202] argued that the deterrence effect of informal payment was not necessarily undesirable insofar as informal payment restricted unjustified consumption (resulting from the excess demand at zero price), i.e. it worked in the same way as a co-payment.

Apart from any impact on the allocation of resources and the distribution of income, benefits and costs of health services, many researchers pointed a positive feedback effect, with the characteristics of informal payment encouraging its further spread and thus obstructing health care reform. Galasi and Kertesi [202] argued that any perception by non-paying patients that they received worse care than paying patients might make them begin to pay in order not to lose out against paying patients, whilst Kuti [70] pointed out that as informal payment became customary, people would feel obliged to give it. From the provider's perspective, Ádám [49] described a downward spiral in which the existence of informal payment justified low salaries, which in turn justified greater acceptance of payments, and so on. Among others, Petschnig [85] and

Csaba [69] raised the possibility that the spread of informal payment was also encouraged by a growing weakening of 'moral consciousness' among physicians as increasingly few felt any internal conflict in accepting them. Moreover, Csaba [69] noted that informal payment influenced the patient-doctor relationship in ways that increased its acceptability. He argued that the information asymmetry between patients and doctors could make informal payment a dysfunctional form of communication. For instance, refusal of an offered payment might cause the patient to believe that there was no hope for recovery; in contrast, accepting informal payment became a *"sign of hope"*.

Finally, many writers on informal payment, including Balázs [64; 73] and Buda [9] argued that payments endured because their presence served to block attempts at health care reform by those who benefited most, usually those at the top of the medical hierarchy.

3.4.3. BRINGING TOGETHER THE ARGUMENTS: EFFICIENCY AND EQUITY

CONSEQUENCES OF INFORMAL PAYMENTS

Table 3.1 summarises the contrasting arguments concerning the impact of informal payments on system performance, distilled from the above debate. This offers a means of determining how different mechanisms will impact on resource allocation and the distribution of cost and benefits of services, i.e. the efficiency (cost-effectiveness) and equity (equal access for equal needs) of the health care system.²⁰

Table 3.1.

Hypotheses concerning the actual impact of informal payment on the performance of the health care system

Level	Hypotheses
Demand side (patients)	voluntary gratitude payment
	feel obliged to give to receive adequate care
Supply side (physicians)	same service
	better/more service according to need
	supplier induced/reduced demand
Supply-demand interaction	no change
	redistribution of existing services (co-payment like mechanism)
	extension of services (price mechanism)

²⁰ As we have discussed in chapter 1, the goodness or badness of a particular effect of informal payment depends on the decision-makers' views of the competing health policy objectives and the priorities set among them. Whilst in Hungary no explicit prioritisation of the policy objectives has taken place, at least there is agreement on which objectives count and how to interpret them. So we relate the hypothesised effects of informal payments put forward so far to the extra-welfarist notion of efficiency (cost-effectiveness) and the definition of equity that involves equal access for equal needs.

As the theoretical debate shows, the impacts on efficiency and equity could differ markedly depending on assumptions about how informal payment works. First, it is important to distinguish whether patients give entirely voluntarily or feel obliged to pay. Second, does informal payment behave like a gratitude payment, a co-payment, or a price mechanism?

A voluntary gratitude payment should not alter either resource allocation or the distribution of services, whilst a 'compulsory' co-payment may not just restrict unnecessary services, but either deters the poor to utilize health services or place a disproportionate cost burden on their shoulders. This is not just an equity problem, but adversely affects resource allocation (cost-effectiveness) insofar as services are not consumed by those who would benefit the most. On the other hand, the equity impact of informal payments might be mitigated if physicians are able to price-discriminate among patients according to their ability to pay.

Furthermore, even if the aforementioned co-payment is given voluntarily, the impact of informal payment on system performance depends on what is given in exchange. From the equity point of view any difference between paying and non-paying patients implies unequal access for equal needs, regardless whether or not all services are distributed among patients within existing capacities. However the relationship between supply and demand (or need) determines the impact of informal payment on efficiency, and in this respect it becomes important if physicians manipulate supply (supplier-induced/reduced demand).

If we attribute to informal payment the characteristics of a price mechanism, as argued by Antal [71; 153] and Bondár [63], we cannot exclude the possibility that it contributes to the expansion of supply by means of political connections and lobbying, and this may increase the efficiency of the system by alleviating shortages. Nevertheless, any effect will depend on where and how resource reallocation takes place.

On one hand, if shortage exists throughout the health sector, and overall health expenditures are not increased, resource reallocation between specialities (and services) increases cost-effectiveness only if patients' willingness to pay for a particular service coincides with the dominance of this service over others in terms of cost per unit of health gain. Moreover, as Csaba [69] noted, increased capacity does not necessarily diminish informal payment, since physicians are able to induce demand and maintain

shortage. In any case, however, reallocation can also have adverse distributional impacts.

On the other hand, if supply is expanded with additional resources, both paying and non-paying patients may be better off, insofar as the benefits of improved standards spill over to non-paying patients. Whether efficiency is really improved, however, depends on the benefits forgone from not using these resources elsewhere, as argued by Galasi and Kertesi [202].

In most of these scenarios, paying patients cannot be sure that they receive the care that they want, as pointed out by Petchnig [85], Antal [71; 153] and Csaba [69]. This is not just related to the opportunistic behaviour of the physician, manifested in supplier-induced demand. Even if the physician seeks to act in the best interest of the patient, there is a degree of uncertainty about the outcome of any intervention. The very fact that consumers in the health sector have limited information about their need (wants), and in many cases the outcome of the service provided is uncertain and difficult to judge, separates the motivation of the patient from the impact of informal payment on system performance. This separation differentiates voluntary gratitude payment from those cases of informal payment given in the hope of obtaining better care, whereas paying patients receive exactly the same service as non-paying ones. From the policy point of view, the motivation of the patient is more important than the actual impact, since the potential is always there, and the appropriate policy tools could be very different to address either a cultural issue or shortage of capacity. In this respect, it is less important whether there is a real shortage or just one that is perceived by patients.

Finally, informal payment tends to be a self-reinforcing phenomenon as, once it emerges, its characteristics lead to it becoming embedded in the system and diffusing through it. This is not only related to its nature as a dysfunctional tool of communication or the politics of informal payment. The presence of informal payment may give rise to a process of selection in which those who reject it on moral grounds will be less likely to choose medicine as a career while those who are more 'materialist' will dominate the profession.

3.5. Summing up the debate: 'fee-for-service' or 'donation'?

The theoretical discussions involve many different views and comprise quite complex argumentation but it is possible to distil two main hypotheses that capture the essence of

the phenomenon from the perspective of its impact on system performance and the effectiveness of various policy tools to tackle it (Table 3.2).

Table 3.2. Two contrasting hypotheses of informal payment

	Fee-for-service	Donation
Origin of informal payment	State-socialist health care system (system dependent)	Before the communist regime (culture dependent)
Causes, preconditions	Shortage (health care system performance failure)	Tradition, culture
Patients' principal motivation	Ensure quality care	Gratitude
Health workers' principal motivation	Make ends meet	Refusal would adversely affect patient-doctor relationship
Impact on efficiency	Negative or positive	No
Impact on equity	Usually negative	No or minor

3.5.1. THE ‘DONATION’ HYPOTHESIS OF INFORMAL PAYMENT

The first, which we call the 'donation' hypothesis, builds on the social-cultural and ethical explanations of informal payment. In its pure form, the donation hypothesis was described by Szabó [72]. Patients are grateful to physicians for having been cured from an illness. Health is so valuable that it is not possible to pay for it, but patients would at least like to express gratitude in the form of gifts. This kind of present is entirely voluntary and always happens after treatment is completed. Thus, informal payment is in fact gratitude payment (gratuity), which possesses the same characteristics as a donation. It is important to note that development of the gratitude concept is not an exclusive feature of the Hungarian health care system. For instance, it is seen in Poland [104; 105], in Bulgaria, where the Bulgarian Physicians' Union uses this distinction to justify ex post informal payments [74], and it has been described in countries of the FSU [96; 102]. In Hungary, the Medical Chamber is the most 'devoted' advocate of the gratitude payment concept. As Buda [9] put it, *"it is integral part of the medical mythology"*, which *"most physicians believe in"*.

According to the ‘donation’ hypothesis, gratitude payment is part of the culture of society, with roots that predate the establishment of the state-socialist health care system. In this respect it is immaterial whether informal payment is closer to the concept of the votive offering proposed by Szabó [72,pp.61-68], Kornai’s tip [207,p.105] or a replacement for a fee, as suggested by Magyar [208,p.140]. The key issue is that the elimination of informal payment would require a change of culture, which is very difficult to achieve, at least in the short term. Moreover, as this phenomenon has no causal link with the state-socialist health care system, the

'donation' hypothesis implies that the relevant policy tools lie outside the organization and functioning of the formal health sector. But should gratitude payment be eliminated at all?

The donation hypothesis implies that informal payment is a benign phenomenon. It brings in additional funds to the health sector, with no (or minor) effect on the equity and efficiency of the health care system. First, it does not deter the poor to utilize health care and second, it does not influence physicians in the choice of services to provide. It is true, that gratitude payments changes the distribution of costs insofar as it fall on patients rather than the healthy, but any equity problem is limited as giving is linked to ability to pay. Nevertheless, irrespective of common cultural roots, there could be subtle differences between a votive offering, a tip and a fee-replacement in this respect. For instance, a tip is usually associated with improved responsiveness, even if clinical quality is not affected. This certainly deviates from the benign gratitude payment concept, but still be closer to that than the other main hypothesis of informal payment, which we call 'fee-for-service'.

3.5.2. THE 'FEE-FOR-SERVICE' HYPOTHESIS OF INFORMAL PAYMENT

The 'fee-for-service' hypothesis represents the other end of the theoretical spectrum. It is based chiefly on the economic explanation of informal payment, whose centre point is shortage. According to this hypothesis, patients seek to ensure that, despite (real or perceived) shortages, they will receive the service they need. They pay health workers informally, who gladly accept the offered payment to make ends meet, and they provide the service that was requested. Whilst the most obvious case is when patients pay before receiving treatment, the timing of the payment is not a crucial issue, not least because the distinction between 'ex-ante' and 'ex-post' becomes somewhat artificial as health care increasingly involves a series of encounters rather than an individual procedure (Appendix F).

In contrast to the 'donation' hypothesis, the 'fee-for-service' hypothesis unequivocally links the origin and genesis of informal payment to the state-socialist health care system through the disequilibrium of supply and demand, with two major policy implications. First, the causes of informal payment are not deeply embedded in society, consequently it is not hopeless to think it can be changed within a generation. Second, the design of the state-socialist health care system is responsible for the phenomenon, which implies that reform of the system may eliminate it. The appropriate policy tools, however, largely depend on the causes of the shortage. It

matters whether this is due to excess demand because of moral hazard, as proposed by Petschnig [85], the existence of a strict referral system that prevents patients choosing their doctor freely, as argued by Kuti [70] and Bóc [196], or insufficient supply as a result of overstretched and demotivated health care staff, as argued by Kuti [70]. A detailed examination of these options is beyond the scope of this thesis, but they will be addressed later in the framework of a new theory of informal payment.

From the perspective of the impact of informal payment on system performance, the causes of that shortage are immaterial. Regardless of the sequence of events that led to shortage and the emergence of informal payment, the 'fee-for-service' hypothesis implies that informal payment introduces the same incentives into the system as a fee-for-service method of payment, with all of its adverse effects on the efficiency and equity of service delivery. At worst, this malign informal payment will prevent access by the poor, placing a disproportionate cost burden on their shoulders, and at the same time it will encourage physicians to provide otherwise unnecessary services or to reduce their performance to elicit informal payment from those who do not intend to pay. As discussed earlier, however, its actual impact on efficiency depends on several factors, including whether informal payment simply redistributes existing services, or is able to expand supply because it encourages lobbying of decision makers. Within a fixed capacity informal payment can improve efficiency if it restricts unjustified consumption of services or if it redistributes existing services to achieve greater health gain. On the other hand, it will reduce efficiency if it deters justifiable demand, but this also depends on whether or not physicians price discriminate among patients, which could also mitigate the adverse effect on equity. Regardless of the actual impact on the performance of the health care system, however, the distinctive feature of the 'fee-for-service' hypothesis is that patients would like to get better services, hence there is always an element of coercion. This 'coercion factor' is not primarily external, and is based on the patients' perception, i.e. patients cannot be sure that they will get necessary services without informal payment (see Appendix F for a more detailed discussion).

So far we have summarized the theories of the origin of informal payment in two contrasting hypotheses. The 'donation' hypothesis builds on the social-cultural explanation of informal payment, whilst the 'fee-for-service' hypothesis adopts an economic explanation. But how do legal-ethical explanations come into the picture? The lack of control and accountability argument of Ádám [66] and Blasszauer [65] is certainly a plausible hypothesis in the genesis of informal payment insofar as it influenced the diffusion of payments. Any theory of informal payment is incomplete

without consideration of this factor, and a legal-ethical perspective highlights the need to extend the 'fee-for-service' hypothesis to include the broader context of the phenomenon. In the following section we attempt to do exactly this, using the arguments contained in the theoretical debate as building blocks of a theoretical framework constructed from Hirschman's [106] theory of *"responses to the decline in firms, organizations and states"* and the theory of government failure [54].

3.6. Extending the 'fee-for-service' hypothesis: informal payment and the theory of 'inxit'

Our theoretical framework is built on two key assumptions. The first is that the underlying cause of the problem is shortage associated with the Semashko system. We argue, however, that restricting the discussion to a particular cause of shortage may decrease understanding of the phenomenon. Instead, many factors contributed to the failure of the Semashko system, which we will accommodate in the context of the theory of market and government failure to gain insights into how publicly funded health care systems develop and react to shortage.

The second key assumption is that informal payment is a reaction by dissatisfied patients and physicians to shortage – a manifestation of deteriorating organizational/system performance. In his 1970 work, *"Exit, Voice, Loyalty"*, Hirschman analyses this situation to gain insight into how people react to *"decline in firms, organizations, and states"*, which leaves consumers' (patients) and employees' (doctors) wants unsatisfied [106]. He identifies two main reactions: (a) *"exit"*, i.e. to leave the situation and satisfy the want elsewhere, and (b) *"voice"*, i.e. complaining using available channels. This latter option assumes, as Hirschman puts it, *"loyalty"* to the organisation/system insofar as voice is usually less effective, more risky (and involves considerable externalities, insofar as the benefits of improvements are also frequently enjoyed by non-complaining consumers or employees).

We argue, however, that while the theoretical literature on informal payment fails to consider other possible responses to shortage (specifically exit and voice), Hirschman's theory does not capture all options and, specifically, cannot embrace the phenomenon of informal payments. To overcome these limitations we apply Hirschman's theory but extend it with a new option, which we call 'inxit'. We complement Hirschman's analysis by examining how the specificities of the health sector influence the development of shortage, and the perception of this performance decline. We will consider the determinants of choice between alternative behavioural reactions, accommodating the

legal-ethical explanation of informal payment. Finally, we will discuss the implications of our cognitive behavioural model for policy-making including the range of policy options that might be used to tackle the problem.

3.6.1. THE STARTING POINT: PUBLIC FINANCE AND SHORTAGE

Drawing on the economic explanations, our theoretical framework links the emergence of informal payment to the development of shortage. But what is the association between public finance and shortage?

According to standard economic literature, the market for health care inefficiently allocates resources and inequitably distributes services among patients [54, pp.289-300].²¹ Providers are assumed to extract extra profit by exercising monopoly power and physicians to earn rent by capitalizing on information asymmetry, i.e. to provide unnecessary services to maximize income, while the market denies access to care to those, who cannot afford payment. Government intervention through public finance can remedy both problems, but can lead to shortage with excess demand and inadequate supply.

First, public finance may be a better means of cost containment through centralization of financing and monopoly purchasing power, but this can go too far, leading to under-provision in relation to expected benefits. Inadequate supply, the argument of Kuti [70], fits well in the government failure framework [54, pp.5-6].²² Even if we set aside the influence of politics on public choice (the less 'powerful' sectors often loose in the quest for public money), which is one source of government failure, determining the efficient level of health care spending requires much complex or unavailable information on needs, costs and consequences of various interventions, another source of government failure.

Second, the rationale of public finance is to ensure that those who cannot afford to pay for health care can get access to services if needed [54, pp.80-81; 53]. Public finance enables patients to express previously unmet needs as demand. Removal of the

²¹ Inefficiency is attributed to the special features of health care as a commodity. The demand for health care is a derived demand for health, which is the underlying condition of most of our everyday activities. Consequently health care has many complementary goods, and few or no substitutes, which in certain cases result in low price elasticity of demand (i.e. patients are willing to sacrifice a lot to get the necessary treatment). Furthermore, patients' ability to determine what health services they want and to judge the outcome of the provided services is limited by the lack of specialized knowledge that only physicians possess, which enables the supplier to determine (and even to manipulate) demand.

²² Stiglitz [54, pp.5-6] distinguished four sources of government failure: (a) lack of information to make appropriate decisions concerning resource allocation and distribution of income, (b) limited control over (→)

price barrier, however, as argued by Petschnig [85], leads to excess demand, insofar as patients over-consume services because they face zero price at the point of utilization (moral hazard). If excess demand is not met by matching supply, shortage inevitably develops.²³

Nonetheless, the tension between cost-containment and excess demand is not specific to Semashko systems, which suggests that public finance and the resulting shortage in themselves do not necessarily lead to informal payments. What were the special features of these systems that made patients react to the problem by paying informally?

4.5.2. EXIT, VOICE AND 'INXIT'

Our cognitive-behavioural model of informal payment takes its point of departure from the 'declining' performance in the health care system, manifested in shortage, which leaves both patients and physicians dissatisfied and provides both groups with a motivation to change the situation.

Applying Hirschman's theory to this situation offers only two options. Either they leave the organization, or the whole system, and satisfy their wants elsewhere, or they decide to remain with the provider (within the system)²⁴ and complain openly if there is a possibility to do so. However, we argue that informal payment is one manifestation of another option: 'inxit', which goes beyond exit and voice. What is the difference between these behavioural reactions?

According to Hirschman, the difference between exit and voice is how and where dissatisfaction with declining performance is expressed. While both exit and voice are corrective mechanisms insofar as they force the organization improve its performance, exit works indirectly, through leaving the organization or stopping buying its products or services, and voice is aimed at directly "*changing the organization's activities, objectives and outputs*" [106, pp.4,30].

Informal payment, however, mixes certain characteristics of both. It resembles voice inasmuch as the dissatisfied persons do not leave the organization (system) but seek to

the reactions of the private sector, (c) limited control over the bureaucracy, and (d) the influence of politics on public choice.

²³ This problem has two components. The first is that there is an additional group of people, who were previously unable to pay for health care and whose needs now become expressed as demand, enabled by public financing. The second is that patients may over-consume services because they face zero price at the point of utilization (moral hazard), although this is a characteristic of the private insurance market too. It should, however, be noted that the separation of these two components is imprecise, exactly because the individuals' valuation of health services is not separable from their ability to pay.

change its activities (at least for the particular service concerned), not through open complaints, but using informal methods, such as payment or connections. These mechanisms are different from the option of voice as they are usually covert and do not involve persons other than the employee and the consumer, generally bypass the established rules of the organisation or the system and they can precede the utilisation of the service. On the other hand they resemble the exit option, insofar as they are depersonalised and generally secure benefits for only the persons concerned. Informal payment can be regarded as an exit mechanism, but within the organisation. Thus it is an informal/internal exit, hence the term 'inxit' (Table 3.3).

Table 3.3. Comparison of possible behavioural reactions to declining organizational performance

	Exit	Voice	Inxit
Place of action	out of the organisation	in the organisation	in the organisation
Method of expressing dissatisfaction	leaves the organisation and satisfy wants elsewhere	open complaints using available (formal) channels; overt	try to satisfy wants in the organisation using informal channels (generally bypass established rules); covert, can precede the use of service; involves only the consumer and/or the employee
Method of improving organizational performance	indirect	direct	direct
Benefits of the action	primarily individual	other users can also benefit (large externalities)	individual, but with the possibility of benefits spilling over to other users

In the initial development of this concept the term 'manipulation of the system' was used, since these informal methods often violate established rules, i.e. were illegal. There are, however, four reasons why we suggest a new descriptive term. First, it is not always illegal, and illegality does not always imply illegitimacy or corruption. Second, 'manipulation of the system' has a negative connotation, which implies undesirability, but this mechanism may serve useful purposes, just like exit and voice. Indeed, Hirschman deliberately chose neutral terms to avoid stigmatising expressions that economists and political scientists alike used to describe each other's mechanisms [106, pp.17-18,31]. Third, the brevity of the word 'inxit' goes better with exit and voice. Fourth, whilst there is no doubt that the most characteristic form of 'inxit' is informal payment, we argue that 'inxit' is a better term to describe the phenomenon, since

²⁴ It is important to note that the option of exit can be understood not just at the level of individual providers, but at the system level. This is where the private sector is an alternative to the public sector, even if there is the possibility to choose between individual providers within the public sector.

informal payment inevitably restricts the richness of the concept in the real world. Even the earliest theorists, such as Petschnig [85], argued that it was impossible to understand informal payment if one overlooked social and political connections as a means to obtain better care. She concluded that *"...patients, who pay with money, often would like to make up for their disadvantaged position in the social hierarchy. Money, as leverage, substitutes the benefit which cannot be obtained at their level of the social echelon."* Buda [9] explicitly linked toleration of informal payments to connections between the medical profession and the ruling elite. On the providers' side, physicians can modify performance, carry out an informal functional privatization by using public facilities for private practice, prescribe unnecessary drugs to obtain bonuses from pharmaceutical companies [104], and tailor performance reports. They can even pilfer drug supplies [98]. These examples extend beyond informal payment and require a broader category.

We argue that Hirschman's model has to be refined in another respect as well. Information asymmetry, a characteristic of health services, complicates judgment of provider performance. Patients may perceive a problem if they do not trust physicians and the system in general, even if there is no real decline in quality. The belief that they will not receive a service of appropriate quality need not arise from their own experience, but from reports of relatives, friends or the media. Thus, a general distrust in the system could develop, related to the loss of social capital in health care (Appendix F).

4.5.3. OPTION APPRAISAL: FACTORS INFLUENCING THE DECISION

But why would a patient or a doctor choose 'inexit'? To explain the choice between the various options, our model works with three concepts: (a) availability, (b) ability to do, (c) willingness to do. We argue that the choice depends on whether the option is available, whether the individual concerned has the necessary means to select the option (ability to do), and whether the potential benefits of exercising an option exceed its costs (willingness to do).

Availability means whether the particular option really exists. If we consider the patient's viewpoint, availability is concerned with the supply of services, while for doctors it usually means demand for their human resource. Ability to do is concerned with the doctors' and patients' individual circumstances in relation to a particular option. For instance, patients are able to exit or 'inexit' if they have the necessary financial resources to do so, i.e. they are able to pay. In the case of doctors, the option

of quitting the system (exit) is very much constrained by possible alternative uses of their expertise.

Willingness to do is concerned with the subjective availability of an option, i.e. on which grounds individuals judge those behavioural responses that are open to them, because all objective conditions to act are given. In general, we hypothesize that this decision involves the consideration of the costs and benefits of the various options, but this should be explored by empirical research. Nevertheless, the theoretical literature summarised above has highlighted a few considerations that we think relevant in this respect.

First, as Ádám [66] and Blasszauer [65] argued, legal ambiguity was an important factor in the evolution of informal payment in Hungary. Ádám [50] pointed out that although informal payment had never been legal in Hungary, official policy tolerated 'gratitude payment', creating the impression in both physicians and patients that it was actually not forbidden. The legality or illegality of a particular action certainly influences an individuals' willingness to do it, but does not guarantee total compliance with the law. Indeed, the individuals' own judgement may be different from legal proscriptions, and if the whole or at least the majority of society think differently, regulations become illegitimate and enforcement becomes difficult, or even impossible [53].

Second, regardless of laws, professional and individual ethical norms can influence what physicians are willing to do in pursuit of their own self interest [192; 70; 69]. A weak sense of duty can encourage the adoption of certain income maximisation strategies by providers. One is supplier-induced demand [209], a phenomenon that becomes important once informal payments become established, creating, *de facto*, a fee for service system. A second is the creation of artificial shortage by, for instance, denying or delaying care (supplier-reduced demand) to elicit payments, as argued by Kuti [70]. Although strong professional norms can limit such practices, ethical provider behaviour might also give rise to informal payments insofar as doctors had to take up part-time jobs to complement poor salaries and the 'exhausted doctor' created the impression of low quality of care in patients [70]. Further, what is considered ethical or unethical is influenced by the 'unacceptably' low official salaries [86], but also the examples of how others behave [202], so that in certain situations informal payments are seen as legitimate.

Third, Hirschman discusses two related concepts in his theory: (a) who are the consumers that are the most sensitive to, i.e. activated first by performance decline and (b) what are the factors that make people stay rather than leave, a concept that he calls "*loyalty*". Hirschman uses the concept of consumer surplus to conceptualize the former question. He argues that whilst a price increase induces the consumer with least consumer surplus to stop buying the product or service, decline in quality makes the consumer with the highest surplus leave, i.e. those who are the least sensitive to price. Hirschman calls these consumers quality-conscious consumers, or "*connoisseurs*" [106, pp.44-54]. The identification of "*connoisseurs*" by means of personal attributes (such as place of residence, education, occupation, income, health status, religion, ethnic origin, age, gender, etc.) could be useful to explore the phenomenon. Furthermore, Hirschman's argument suggests that in this respect service attributes (the type of service, speciality, the level and location of the health care provider, the qualification and position of the doctor, etc.) also matter, since patients probably derive different amounts of consumer surplus from different health services.

Concerning loyalty, Hirschman [106, pp.76-105] identifies one particular factor with obvious relevance to the health sector. He argues that the more difficult it is to gain admission to an organization, what he calls "*severe initiation*", the stronger the loyalty of members will be. This applies to physicians and more importantly to specialists, whose training may take 10-12 years. Another barrier to exit, as mentioned before, is the alternative use of this highly specialized knowledge (if not in the health sector). Using the terminology developed by Williamson [210] physicians exhibit asset specificity, and exit is associated with large sunk costs, which certainly increases loyalty.

3.6.4. THE DECISION TO PAY: EMERGENCE OF INFORMAL PAYMENT

The decision to act according to one of the three options (exit, voice, inxit) has detectable consequences at the system level. Exit, for instance, will result in an increase of private sector activity, and voice will lead to an increase in the number of complaints. The decision to pay and the act of paying at the micro level will determine the overall magnitude and distribution of informal payment. But what determines how much is paid in individual transactions?

We argue that the actual payment is determined by a reassessment of official entitlements both by patients and doctors. As Balázs [211] put it "*informal payment is the interpretation of the official service in the patient-doctor relationship*". Patients

perceive that they do not get what they want, yet judge what it is reasonable to expect in a system with such low-paid doctors. That is, they define a basic level of care (that may or may not be included in the official service) and pay for what else they would like to obtain (i.e. for those 'extra' services for which they are willing to pay). Similarly, doctors think that they are not paid enough for the work that is demanded from them, and thus determine what is reasonable to expect from them for the official salary. If the patients' and the doctors' interpretations coincide in individual transactions, then both their wants are satisfied. Further, if the outcome of this process of reinterpretation of entitlements coincides in the minds of most patients and physicians, then a new, unwritten set of entitlements emerges, for which the choice of physician and receiving home visits provide excellent examples in Hungary. Furthermore, even if the 'reinterpretation' of the official entitlements does not overlap, which is possible as it is left to the individuals' own judgement, doctors are in a position to impose their interpretations on the patient, thereby effectively forcing them to pay.

Figure 3.1. The cognitive-behavioural model of informal payment

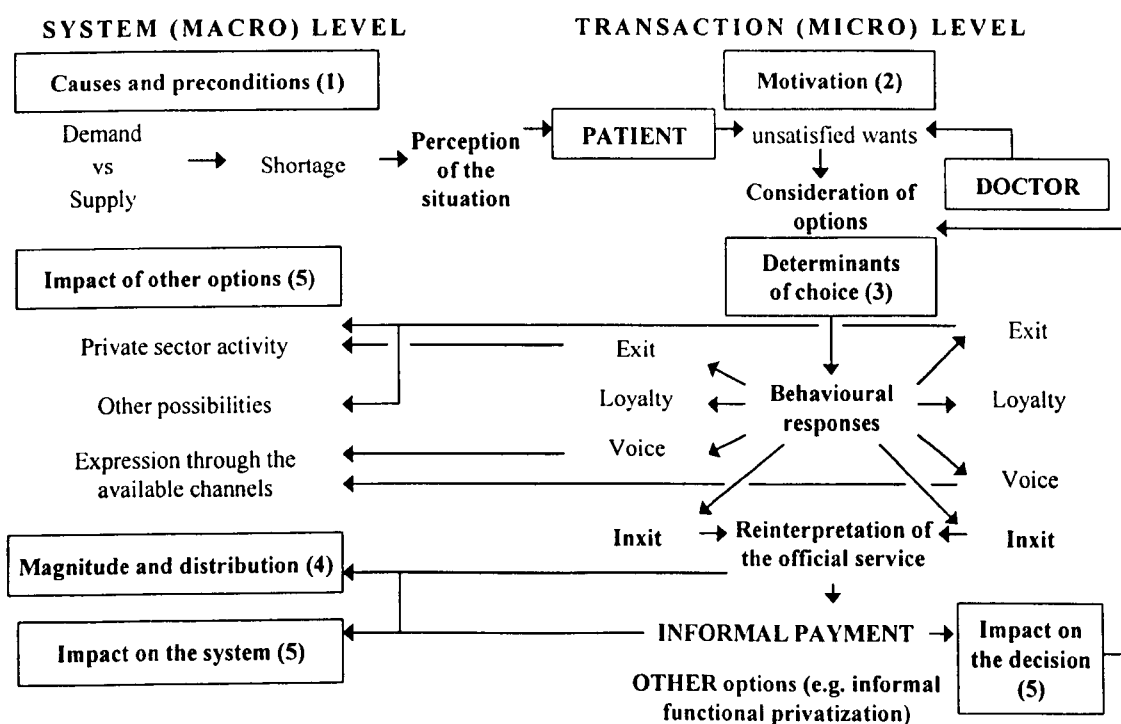


Figure 3.1 summarizes the main building blocks of our theoretical framework as discussed above, and suggests main research areas (numbered) where one might seek empirical verification of it. In essence, we argue that reactions to any performance decline, such as shortage experienced in the Semashko system, are fundamentally

determined by the availability of various behavioural responses, and popular ability and willingness to go for a certain option. The logic of the model suggests that, where exit and voice are not available in a system, the only possible active reaction to the decline in performance is 'inxit', so leading potentially to informal payment.

3.6.5. EXPLAINING INFORMAL PAYMENTS IN HUNGARY

Our model explains the emergence of informal payment in Hungary on the basis of this argument. The establishment of the Semashko system assumed a virtually exclusive role for the state in financing and service delivery (chapter 2). The nationalisation process eliminated the private sector, voluntary private insurance was forbidden, and private practice was confined to a small amount of spare-time surgery. Further, the regime left little room for the public's voice to be heard. The channels of voice were strictly controlled, and complaints were regarded as an assault against the ruling regime. We argue that blocked exit and voice made the Semashko system react differently to shortage than other integrated health care systems, such as the British National Health Service (NHS), thereby aggravating the problem further.

In the Semashko system equity was a prime objective, guaranteeing comprehensive high quality health services for all citizens. Yet this was an unrealistic objective, especially in light of the unfavourable investment policy of the regime, as argued by Kuti [70], and the increased sensitivity of the decision making process to private interests, as argued by Antal [71]. With the suppression of democratic accountability, the communist regime divested itself of the benefits of the checks and balances in a pluralistic democracy, while suffering the disadvantages as private interests continued to operate behind the scenes and distorted resource allocation in health care.²⁵ Furthermore, uniform provision did not allow differentiated wants to be satisfied, for instance the free choice of physician [70], which was explicitly denied along with alternative ways of provision (blocked exit).

Consequently, many found their wants unsatisfied, but the regime would not admit this openly. Instead of developing explicit waiting lists, it pushed rationing decisions down to providers, where shortage was manifested in diluted service quality. The regime used its monopoly power to set health workers' salaries low, especially physicians, initially for ideological reasons [49, p.86], but also to control health care

²⁵ In general, as argued by Stiglitz [54, pp.5-6], the prerequisite of effective government intervention is adequate information and the neutralization of interfering private interests. In a pluralistic democracy (→)

expenditure. However, low salaries in themselves could have caused shortage (through overwork, and/or manipulation of performance), as argued by Kuti [70], given no alternative employment options for health workers.

In summary, the system was unable to provide what doctors and patients wanted (or at least patients perceived a performance failure), which consequently led to the activation of the 'inxit' mechanism, because no other option was available. The regime tolerated informal payments, they gained legitimacy and became widespread. Moreover, the initial shortage was worsened by the challenges brought about by the end of the 1960s with the revolution in health technology and the deteriorating health of the population [40; 39] and the inadequate policy responses with quantitative development instead of quality improvement [40; 52]. The policy of tolerating informal payment continued until it was included in the taxable income of physicians in 1989 [8].

3.6.6. EXPLAINING OTHER COUNTRIES' EXPERIENCES: THE REACTIONS TO PERFORMANCE DECLINE REVISITED

So far we have explained the emergence of informal payment in Hungary, which we contend applies to other former state-socialist health care systems. But what happens if there is a decline in performance of public services, such as deteriorating quality or increased waiting times, and exit is not blocked?

Hirschman [106, pp.44-54] argues that in those situations where there is a private alternative to the public service, 'exit' may deprive the public system of those who would be willing to act (complain) to improve performance, should they choose to stay. Arguably some of the current problems of the British NHS are examples of this, as many potentially vocal patients have opted for exit, using the private sector.

Further, the existence of a private alternative limits governments' ability to control costs by pushing down physicians' salaries, since mass exit of health workers would threaten sustainability of the public system. To retain human resources, salaries have to rise, but this may divert resources from other areas with consequences for performance decline, and so induce the exit of 'quality-conscious' patients. The system may then split into a poorly performing public service and a well performing private one, echoing Titmuss's [212] famous saying that *"a service for the poor is a poor service"*, as illustrated by accounts of Chilean health care reform [213].

competing interests groups can play a role in both provision of information and development of checks and balances on each other and on government.

The adverse effects of exit from the public sector can be extended to reach a more generalized conclusion. Suppose there is a private alternative to public services and workers do not leave, but instead complement their salaries from a part-time private job. Public services can still suffer insofar as workers concentrate their efforts on their other job, from which more income can be expected. This can reach the point where physicians do not even turn up for their public sector employment. This 'show up' problem has been reported in certain Latin American and African countries [98]. In this situation informal payment can lure the physician to work in the public sector from which non-paying patients may also benefit. The theory of 'inxit' suggests that 'inxit' may be preferable to exit if benefits spill over to other users of public services. Informal payment can even induce the extension of supply through lobbying at the national level, as suggested by Antal [71] and Bondár [63].

Nevertheless, we argue, that governments' ability to control costs by pushing down the price of human resources is limited even if there is no private alternative to public services, because the government has limited control over private responses (yet another source of government failure described by Stiglitz [54, pp.5-6]). 'Inxit' can be activated by low pay, since health workers can choose to restrain performance, as suggested by Kuti [70], but even if there is no apparent performance decline, patients can perceive such a problem ('can I reasonably expect that this low paid physician will do her/his best to provide the service that I want?'), and it is very difficult to prevent those who want better service to get it if they can afford to pay for it. On the other hand "*connoisseurs*" represent a driving force for performance improvement and policy makers should find innovative ways to harness this force for the public benefit. If they choose exit, the public sector loses not just their additional money but their willingness to criticize poor performance. There is the potential risk that the split between the public and the private sector will widen, leading to a downward spiral of quality in the public sector. However, if they stay in the public sector, there is the risk of incorporating this split into the public sector with the additional problem of diverting public money to support private wants. We argue that an understanding of this dilemma is crucial to finding the appropriate policy response to informal payments and that the increasing popularity in some countries of a market-based response that simply creates the conditions for exit is unlikely to yield the best possible outcome for the public system.

3.6.7. POSSIBLE SOLUTIONS

Hungarian researchers advocated various proposals to tackle the problem, reflecting their theories about the causes. Table 3.4 reviews these proposals, which range from "voluntary gratitude cheques", essentially a method of incorporating feedback from patients into the remuneration of physicians without actually taking money from them [195], to increasing the pay of health workers coupled with prohibition of acceptance of informal payments [66; 65].

Some proposals have already been implemented in Hungary (chapter 2): a social insurance system was introduced and provider payment was changed to capitation in primary care, fee-for-service points in outpatient specialist care and DRGs for acute inpatient care. Moreover, the strict referral system of the communist era has been relaxed; since 1992 people can choose their primary care physician. However changing the financing system did not increase resources in the health sector; health workers remained poorly paid. Most notably, economic recession in the first half of the 1990s was followed by a strict cost containment policy, but policy makers proved reluctant to review coverage by the public system or introduce co-payment. There was no change to the policy of tolerating informal payment, which must be declared in tax returns. Although exit and voice are no longer blocked, the private sector remains insignificant. Not surprisingly informal payment has not disappeared from the Hungarian health care system [214].

Table 3.4. Proposed solutions for eliminating informal payment from the Hungarian health care system

Policy tool	Source
Voluntary "gratitude cheque"	[195]
Prohibition and legal enforcement	[66; 50; 49; 65; 68]
Pay-rise of physicians (in combination with other measures)	[66; 67; 65]
Patients' free choice of providers	[70; 196; 67]
Some form of co-payment	[85; 195; 66; 70; 52; 69]
Output-based provider payment methods	[52]
The considerable restriction of social insurance financed services	[211]

Nevertheless, it may not be so bad that unsatisfied patients have not moved to an expanding private sector, since it is still possible to retain most of them and channel the force they represent for the benefit of the public system, using innovative methods of control and accountability (voice). But to make sense of this, we argue that the design of the social insurance system must be appropriate, as it is unlikely that most "connoisseurs" will stay in the public system if there are not enough resources to provide sufficient quantity and quality of care for them. The logic of our model

suggests this as a crucial element in the failure of previous reforms. First, publicly funded services should pursue realistic objectives concerning what is affordable. This should include the definition of a package of services provided at a reasonably high standard for everyone within the funding available, and the funding should cover all the costs of providing these services, including a higher salary for the health workers. Second, entitlement to these services should be made unequivocally clear to the public. But even if users are fully aware of their entitlements and the system is able to provide them, informal payments may persist if there is insufficient trust in the system. Consequently, a comprehensive policy to eliminate informal payments should also address the loss of social capital. Third, we argue that a move from dilution of services to explicit waiting lists (insufficient quantity), would not improve the chance of keeping "*connoisseurs*" in the system.

While the incorporation of private financing in the form of co-payments or complementary private insurance could be seen as a way to improve viability of the public system, it requires great caution because of implications for equity. It is important that the poor should not experience worse access to care than at present. In this respect definition of a benefit package involves difficult decisions. The alternative is to think in terms of non-medical aspects of care, but that is very difficult to separate from clinical quality (for instance if paying patients are ultimately treated by the best clinicians) and a legal two-tier system may emerge.

We propose an alternative possibility. If patients regard free choice of physician as an 'extra service' not covered by social insurance, consumers could take out complementary insurance, whilst the non-insured must utilize services according to a strict referral system, as in Denmark. If patients with such complementary private insurance need care they could choose the doctor freely in the public system, and the insurance company would pay the physician a fee, thereby utilising formal private sources to increase the remuneration of doctors. However, to avoid patients without private insurance being neglected, physicians, who treat these patients, would receive the same, or at least a similar amount from the social insurance fund for each patient treated.

Nevertheless, the usefulness of our analysis depends on the validity of the 'fee-for-service' hypothesis on which the outlined theory of 'inxit' is built.²⁶ There is still a need

²⁶ Should gratitude payment prove to be a valid concept, there will be still a challenge policy makers face, whether it is feasible to separate gratuities from other (coerced) informal payments. A good example of (→)

to examine the extent to which there is a deep-seated cultural dimension to informal payments, which ultimately remains a question for empirical research.

3.6. Conclusions

In this chapter we have reviewed the theoretical literature on informal payment with the aim of providing a consistent definition and contrasting and summarizing the various arguments, exploring their implications for policy-making, and synthesising the various arguments into a theoretical framework that places the phenomenon in a broader context. First, the existing definitions have been reviewed and a new definition has been proposed, which describes informal payments as an additional contribution above what is determined in the terms of entitlements. Second, the various theories of the causes of informal payment have been discussed and three main groups of explanations have been identified (social-cultural, legal-ethical, and economic). Then the views on the assumed impact of informal payment have been contrasted and summarized in terms of efficiency and equity objectives of health policy and the main arguments integrated in two contrasting theories, which we call 'donation' and 'fee-for-service'. The former is rooted in the socio-cultural explanations of informal payment, assuming that patients pay because they are grateful for being cured and that this gratitude payment has no impact either on access to care or efficiency whilst it brings in additional financial resources into the system. Based on the economic explanations, the latter assumes that patients give because they want to have decent care in a system that exhibits chronic shortages. According to this 'fee-for-service' hypothesis, informal payment may prevent access to care for the poor and may induce the provision of unnecessary services, although the possibility of beneficial effects on efficiency and only a modest negative impact on equity can not be excluded. While the two theories have been contrasted to emphasise their differing implications for policy making, it is possible that the two co-exist within the same health care system. From the health policy point of view what is important is which one is dominant.

On the basis of the 'fee-for-service' explanation of informal payment and using the arguments of the theoretical debate as building blocks, we have outlined a new, cognitive-behavioural model of informal payment. It is the theory of 'inxit' as it extends

this dilemma is brick payments [104,p.21], which have been described in the previous chapter. Is it possible to separate forced 'donations' from voluntary donations? If not, should all donations be banned, because it turns out that sometimes patients feel obliged to give, because they fear that they will not get adequate care otherwise?

Hirschman's theory of *"exit, voice, loyalty"*, which he identified as the main *"responses to decline in firms, organizations and states"*. We argue that 'inexit', whose most obvious manifestation is informal payment, is another option, which mixes the characteristics of voice and exit. If both exit and voice are blocked, as was the case in the state-socialist health care systems, the only reaction to shortage is 'inexit' (apart from doing nothing). The model advocates that solutions for informal payments and the failures of the Semashko system in general should balance mechanisms based on both exit and voice.

The framework seems to be applicable to the explanation of many other situations, and it generates plausible hypotheses not just in the narrow topic of informal payment, but concerning more general dilemmas of health care systems. These include, among others, the question of two-tier health care, the role of public financing in health care, its functioning, shortcomings and the effectiveness correction mechanisms, and whether these dilemmas are really confined to the public sector. Indeed, before the establishment of the state-socialist care system in Hungary, public and private insurance companies financed health care. It was widely held that insurance companies exercise their market power to push down the fee (salary) of practising physicians, and thereby *"expropriate their work below its real value"* [7; cited in 8, pp.10-11]. The theory of 'inexit' does not exclude the possibility that there are other models of health care system that may give rise to informal payments. For instance, it is theoretically possible that a private insurance based system would give rise to informal payment if insurance companies are powerful enough to press down the market price of services resulting in diluted clinical and/or service quality. Yet the insured may not be able to shift to another insurance company, because of its associated costs, especially those, who are at higher risk of illness, as existing conditions are usually excluded from coverage. If the insured considered voice too costly, 'inexit' might remain the only choice.

Nonetheless, the usefulness of the predictions of our explanatory theory crucially depends on the validity of the fee-for-service hypothesis of informal payment. In Appendix F we have already raised some theoretical arguments and indirect international evidence against the donation hypothesis. The circumstantial evidence presented in cross-national comparisons suggests that there is a causal link between the lack of financial resources and the extent and types of informal payments. We have discussed the interpretation of 'coercion' as well as what makes a gift. In any case, the validity of the gratitude payment concept remains an empirical question, which should be answered by empirical evidence.

CHAPTER 4.

4. RESEARCH AGENDA AND EMPIRICAL EVIDENCE

In the previous chapter we have argued that, from the policy perspective informal payments can either be seen as 'donation' or 'fee-for-service'. On the basis of the latter hypothesis, we have developed a new theory of informal payment, the theory of 'inxit', which has generated certain predictions about how to approach this issue and has provided a possible explanation as to why informal payments have persisted in Hungary and other former communist countries. Nevertheless the validity of all hypotheses generated by this model is fundamentally determined by the validity of the assumption that informal payment is similar to 'fee-for-service', which is an empirical question. Consequently it must be confronted with empirical evidence.

This chapter first explores further the implications of the 'donation' hypothesis to formulate a research agenda with the help of which the available empirical evidence can be systematised. We pose research questions and corresponding hypotheses derived from the gratitude payment concept, according to the main research areas identified in chapter 3. Then the available empirical studies are reviewed and the available evidence is summarised to see to what extent it is sufficiently conclusive to support the 'donation' as opposed to the 'fee-for-service' hypothesis of informal payments.

4.1. Research agenda

The focus of this research is the question of 'why do patients pay informally for health care?' for which the 'donation' and the 'fee-for-service' explanations provide conflicting answers. But, as we have argued in chapter 1, from the viewpoint of the policy maker it is irrelevant whether informal payment is a donation or a fee-for-service, if it is not sufficient to exert any detectable system level impact. Hence the scale of informal payments should first be established.

If informal payment proves to be important in terms of its scale, the central question of policy making is whether it adversely affects the performance of the health care system, which, as we have argued before, crucially depends on the validity of the 'fee-for-service' versus the 'donation' hypothesis. Both explanations involve a complex set of assumptions and predictions, from the causes and preconditions of informal payment to policy options for how to tackle it. The consideration of all these interdependent hypotheses allows us to relate a wider range of empirical evidence to the question of 'why pay informally for health care?'.

Using the main research areas outlined in Figure 4.1, and the contrasting characteristics of the 'donation' versus the 'fee-for-service' hypothesis summarized in Table 4.3, we propose a possible research agenda by summarizing the research questions, hypotheses and relevant pieces of evidence in Table 4.1 that could be used to verify or refute the gratitude payment concept. We focus on 'gratitude payment', the key concept of the donation hypothesis, since, as we have argued in chapter 3, it is sufficient to demonstrate that informal payment is not 'gratitude payment' to consider it a source of policy concern. If informal payments are not motivated by gratitude, the potential for adverse effects is always there, even if it is not possible to demonstrate these effects in each case. Rejecting the cultural roots of the phenomenon would justify intervention in the system, even if selection of the most effective policy options would need further consideration.

Table 4.1. Research agenda

Main research area / Research questions	Hypotheses ('Donation')
(4) Magnitude and distribution	
Is it worth paying attention to the phenomenon?	Scale is indifferent
(3) Determinants of alternative behavioural options	
Personal attributes or service characteristics?	Large variations in personal attributes even for the same service
What is the attitude of patients and the general public towards informal payments?	Indifferent or positive
(5) Impact on the system	
Does it influence access to care?	No
Does it influence the distribution of cost burden of care?	Yes, but payment is a function of ability to pay
(6) Policy options and the politics of informal payment	
Does informal payment exist in a pure private setting?	Yes
(1) Causes and preconditions	
Did informal payments exist before World War II in Hungary?	Yes
What are the special features of health care systems, where informal payments exist compared to those systems where they do not exist?	Culture
(2) Motivation of the actors	
What is the principal motivation of the actors?	Gratitude
Does the stated motivation fit with the circumstances of payment?	Yes

Indeed, a key assumption of the 'donation' explanation is that informal payment is a national tradition with cultural roots. If this is true then it would have existed in Hungary before the establishment of the communist regime, and the distinctive difference between the Hungarian and other otherwise similar health care systems that have no informal payments is cultural.

The impact of informal payment on equity can also be used to test the validity of the gratitude payment concept. If informal payment really is a gratitude payment then it should not be a barrier to access to care, and even if it changes the distribution of the cost burden of care between the healthy and the sick, the gratitude payment concept assumes that patients do not voluntarily shoulder disproportionate financial burden. However, if there is a 'coercion factor' in giving, one can expect that patients do make sacrifices, for instance using their savings, borrowing money or selling household assets to pay (or simply choose not to utilize health services).

The experiences of the reform measures that have been implemented so far can also inform us about the validity of gratitude payment concept. If gratitude payment persisted in a pure private setting, that would support a cultural explanation.

The study of the determinants of alternative behavioural reactions could provide further evidence. The concept of gratitude payment assumes that the amount of payment is determined by the payers themselves. That is, the amounts of informal payment should exhibit large variations even if informal payment was given for the same service in the same health care institution. However, if informal payment is rather a fee for service, then the amount of informal payment given should be the same or similar, even if patients differ in terms of personal attributes, such as education, occupation, gender, etc. Furthermore, the donation hypothesis implies that patients and the general population have a positive or at least an indifferent attitude towards informal payments, as people are unlikely to do something voluntarily if they disapprove of it.

However, as we have argued in chapter 3, ultimately the principal motivation of the participants determines, whether a payment has been given truly voluntarily or has been forced, in its wider sense. The aim is to capture this 'coercion factor' in the transactions, which requires a broader analysis of the situation that relates the stated motivation to the circumstances of giving. For instance, the 'donation' hypothesis assumes that patients have not lost trust in the health care system to deliver adequate care, that gratitude payment is associated with satisfaction with the service used, that patients pay after the service, that there is no real or perceived difference between services provided, that payment is not associated with any expectations for future episodes of care, and so on. The detection of the 'coercion factor' requires an exploration of these associations.

4.2. Summary of empirical research on informal payment

There is a growing body of evidence that informal payments for health care are both widespread and enduring, not just in Hungary but elsewhere, in particular in the former communist countries of CEE and the FSU [96; 94], many other low and middle income countries [98; 99; 215; 92], but also in more developed countries of Western Europe, where they are still substantially under-researched [205]. The available evidence on the scale of the phenomenon suggests that informal payments are not only widespread, but in certain countries, such as Georgia, Azerbaijan and the Russian Federation, the most important source of health care financing [96,pp.16,19].

Despite growing international interest in the issue, the literature on the empirical research of informal payments is still limited. The few publications in peer-reviewed journals and the conspicuous lack of cross-national research, as well as an absence of research in certain countries does not necessary mean that the phenomenon is under-researched in all countries. Rather the language in which empirical research is published may make it poorly accessible, but even those reports available in English have rarely published subsequently in peer reviewed English language journals so far. For instance, Lewis [96] reviewed 26 empirical studies from 15 post-communist countries of CEE and the FSU. The findings of 24 of these studies are available only in the form of internal research reports, 15 of which are drafts or "*informally reproduced works*" that are not easily accessible. Or, from the 22 studies that have been implemented so far in Hungary, only three are available in English [67; 216; 214] and only one in a peer-reviewed English language journal [67]. Furthermore, the review of the literature has been complicated because informal payments have frequently been addressed only as a side issue in studies with a wider focus [e.g.217; 92; 204].

The strategy of searching the literature thus comprised two equally important components. I have searched the main electronic databases (BIDS, MEDLINE, HEALTHSTAR) using a wide range of broader (bribe, bribery, black-market, informal economy & health care) and more specific (informal, unofficial, under-the-table, under-the-counter, under-the-bed, envelope, gratitude payments, gratuities & health care) search terms to identify relevant literature, then followed up cited references including grey materials. I have contacted researchers directly to obtain material that otherwise would not have been accessible. Findings of 9 out of the 22 empirical studies in Hungary presented here come from grey sources, which illustrates well the need for this latter approach.

4.2.1. EMPIRICAL STUDIES IN HUNGARY

Table 4.2 gives an overview of the research carried out in Hungary between 1969, when the first empirical research of this kind was implemented, to the present (see Appendix E for a more detailed description of studies). So far 22 independent studies have been undertaken on informal payment in Hungary, but only two had informal payment as their focus (TK-1985; TÁRKI-1998). Most are surveys, sometimes in combination with other methods, such as content analysis (TK-1985), unstructured (MTA-SZKI-1988) and semi-structured interviews (TÁRKI-1996). In addition there are two independent sets of in-depth interviews (MTA-SZKI-1983; SZEKI-1983-84) and one historical analysis [49]. Only six of these studies targeted medical doctors, of which two also looked at other health workers (DOTE-1970; ELTE-1973; SZEKI-1983-84; TÁRKI-1998 and TÁRKI-1992,1996, respectively). Although the quality of the studies is uneven, the findings and the lessons of the methodological approaches form a valuable starting point for further research.

4.2.2. INTERNATIONAL EXPERIENCES

Informal payments have been reported in at least 22 countries in three continents. Among the former communist countries, the phenomenon has been documented in Bulgaria [74; 93], the Czech Republic [218; 219], Poland [87; 204; 105], Romania [88], Slovakia [220], the Russian Federation, Kazakhstan [101], Estonia [102], Albania, Armenia, Azerbaijan, Georgia, the Kyrgyz Republic, Macedonia, Moldova, Tajikistan and Ukraine [96; 94], with the possible exceptions of the former German Democratic Republic [220] and Slovenia [96]. There is evidence that the phenomenon is known in Greece [221; 90-92], China [100; cited in 101], Vietnam [215; cited in 96], Uganda [98] and Bangladesh [99].

Unfortunately, in most of these countries, there is little empirical literature that goes beyond simply demonstrating the existence of the phenomenon. At the beginning of this research I was aware of only four studies: two from Bulgaria [74; 222], one from the Czech Republic [218] and one from Poland [87]. Only two of these reports were written in English. Since then the English language literature has broadened [see 96; 102; 103; 95; 104; 94], amongst which the most important is a review by Lewis [96], who summarised 26 empirical studies on informal payments in 15 post-communist countries. It is probable that the literature from individual countries concerned is wider than this, but the language barrier reduces accessibility. Nonetheless, even the majority of the reports reviewed by Lewis are not generally accessible.

Table 4.2. Summary of empirical research on informal payment in Hungary

Research (source)	Nationally representative	Sample size (response rate)	Remarks
SURVEYS			
1. Households/general population			
OTKI-1969 [77]		459/?(?)	
DOTE-1973 [190]		461/500(92.2%)	
OTKI-1984 [201]	+	20,103/20,204(99.5%) (in 7,398 households)	
TK-1985 [79]	+	1,000/?(?)	
GKI-1986 [200]	+	13,500/16,000(84.4%)	
SZGTI-1992 [223]	+	2,000/?(?)	
SZGTI-1994 [75]	+	5,000/?(?)	
SOTE-1995 [224]	+	12,640/?(?)	
KSH-1997 [225]	+	2,682/2,879(93.2%)	
TÁRKI-1996 [216]	+	1,500/?(?)	
TÁRKI-1998 [214]	+	1,392/?(?)	
2. Patients			
OTKI-1970 [226]		718/?(?)	
OTKI-1972-73 [78; 227]	+	4,396/9,898(44.4%)	
County-Hospital-Eger-1973 [80]		1,046/4,300(24.3%)	
OTKI-1981 [81, preliminary report; 228]	only for inpatients	1,606/3,000(53.6%)	
MTA-SZKI-1988 [71; 217]		294/?(?)	
TÁRKI-1996	+	1,008/?(?)	primary care outpatients
3. Physicians			
DOTE-1970? [82]		130/300(43.3%)	
ELTE-1973 [198]	+	?/?(?)	
TÁRKI-1992 [229]	+	1,000/?(?)	
TÁRKI-1996	+	1,351/?(?)	family doctors
TÁRKI-1998		1,006/?(?)	
IN-DEPTH INTERVIEWS			
1. Patients			
MTA SZKI-1983 [199]		99	
MTA-SZKI-1988		294/?(?)	follow-up interviews
2. Physicians			
SZEKI-1983-84 [83]		100(?)/?(?)	
TÁRKI-1996		272/296(91.9%)	semi-structured
HISTORICAL ANALYSIS			
Ádám [50; 49; 67]			
CONTENT ANALYSIS			
TK-1985 (Vágó, unpublished)			

Following the framework presented in this thesis, the following sections provide a summary of what has been found out about the phenomenon so far, on the basis of the literature review of empirical studies in Hungary. Where relevant, the analysis of available evidence is complemented with international experiences. Evidence from

other countries might help to reinforce the Hungarian findings, or can call attention to important differences. In any case they deepen our understanding of the phenomenon.

4.2.3. LIMITATIONS

The findings of empirical studies do, however, have to be interpreted with caution, because of limitations originating from the study designs and implementation. These limitations affect the internal and external validity (generalisability) of research results, and complicate comparability, for instance to assess trends using findings from different studies.

First, studies have applied different frameworks to the definition of informal payments in terms of the media of transaction (cash or in-kind payments), participants (physicians, nurses and other health workers) and motivation (gratitude payment, paying for private services in public institutions). Some studies considered only cash payments (DOTE-1975; TK-1985; GKI-1986; SZGTI-1992,1994; KSH-1997), others cash and in-kind payments (gifts) together (OTKI-1969,1981,1984; TÁRKI-1996,1998), while only the OTKI-1972-73 study addressed them separately. Similar inconsistency is discernible in the recipients of informal payments. There are six studies that distinguished the receiving persons (physicians, nurses and other health workers) (OTKI-1972-73,1984; TK-1985; SZGTI-1992; KSH-1997; TÁRKI-1998). The OTKI-1969, TÁRKI-1996 and DOTE-1973 studies, however, exclusively dealt with physicians, the GKI-1986 and OTKI-1981 studies considered doctors and other health workers, but using the same questions, the SZGTI-1994 research simply used the term ‘gratitude payment’ without referring to whom exactly it was given, while the study in the County-Hospital-Eger-1973 is the most interesting in this respect, because Csapó [80] applied two different approaches in the frame of the research.²⁷ As we have discussed in chapter 3, operationalising informal payment using the term ‘gratitude payment’ could be another source of inconsistent categorisation. The GKI-1986, the SZGTI-1992 and 1994 studies employed this concept, and there is evidence from the former study that respondents mixed gratitude payments with tips (*“tip to nurses”*), which the researcher considered a separate category [200]. The division is not clear between informal payments and payments for private services, either. For instance the SZGTI-1994 study differentiated between gratitude payment and payment for private

²⁷ In the study at the County-Hospital-Eger-1973, three questions addressed the topic of informal payment. Two of them were asked about payments to medical doctors, while the third that to doctors and other hospital staff, all three in different context [80].

practice in public institutions, by operationalising the latter as *"visiting the physician in a public provider institution as a paying patient"* [75]. Whether this was a straightforward distinction for all respondents is not evident, while other studies left this area unexplored and hence uncertain.

Second, the validity of research findings has been affected by selection, respondent and recall bias. Selection bias is manifested in the choice of study population, inclusion-exclusion criteria applied, response rates and non-responses. The OTKI-1969,1970,1981, the DOTE-1970,1973, and the County-Hospital-Eger-1973 studies selected samples from households, the general population, patients and physicians that were not representative nationally. Furthermore, the exclusion of certain sub-groups also questions the generalisability of certain research findings. For instance the OTKI-1972-73 study of hospital patients excluded short term stays (less than 5 days), thereby excluding most normal deliveries, who have frequently been found to give substantial informal payments. In addition, one of the Achilles heels of certain studies is the disappointingly low response rate: 25% (County-Hospital-Eger-1973), 43% (DOTE-1970), 44% (OTKI-1972-73), 54% (OTKI-1981). Whether this is attributable to the study designs (research methods) or the sensitivity of the issue is unclear, but refusals seem especially likely in studies of this topic. This is supported by the observation that in those studies that addressed informal payments as one among many other topics the number of refusals to answer questions related to informal payment were sometimes much higher than non-responses to other questions. For instance the OTKI-1972-73 study found that between 3.9-11.3% of respondents refused to tell whether or not they paid physicians, nurses and other health workers informally (there were separate questions for each), and those who admitted giving, but refused to tell the exact amount were 1.3-7.7% of all respondents [78]. The corresponding figures in the DOTE-1973, OTKI-1981 and GKI-1986 studies were 19.6%, 18.5%-19.2% and 1.4% (said to be high compared to other questions), respectively [190; 81; 200]. The sensitivity of the issue, however, does not only lead to non-responses, but we must ask whether people answer some questions truthfully, such as on the scale of informal payments and the motivation of giving and acceptance. Harding and Jenkins [230] discuss in detail respondent bias in relation to informal economic activity, and there is some evidence from research in Hungary that informal payment is no exception. In the OTKI-1969 and GKI-1986 studies interviewers noted their observations. Many commented on feeling that respondents did not tell the truth concerning informal payments [77; 200]. Respondent bias among physicians has also been demonstrated in Hungary (TÁRKI-1992), which

corresponds well with the observation of Lewis [96,p.10] in the international context. In conclusion, most experts believe that surveys underestimate the true scale of informal payments [e.g.77; 200; 207; 214], but it is not clear to what extent. It is possible that the sensitivity of the issue has changed over time and vary between places, as informal payments have gained increasing legitimacy in the system, which in turn has increased 'willingness of reveal the truth'. In contrast, others, like Balázs [231], have argued that survey respondents may overstate informal payments, insofar as they perceive the act of payment and the amount given as a symbol of the social class to which one belongs.²⁸

Surveys assess informal payments on the basis of retrospective accounts of health care utilization, which is another problem with validity. The various studies employed different time frames from one month (SZGTI-1992) to three years (OTKI-1984), with the latter raising the possibility of recall bias. While Ékes [200] argued that hospital stays are major family events where it is not unrealistic to expect that even non-affected family members could recollect a year later, Bognár et al. [214] argued that recall bias could lead to serious underestimation of the true magnitude of informal payments, which they sought to overcome by "*refreshing*" questions. Kádár et al. [226] noted that the place of interview also influenced how patients remember to these events. During hospital stays patients have fresh memories of bad experiences, but they may be unwilling to give their honest opinion for fear of the consequences. In contrast, at home after discharge, they may be more likely remember the good things.

Finally, we have to take into account how research on informal payments in Hungary spans a 30-year long period. Many results are dated and hence should be extrapolated to the present only with caution.

4.3. Research findings in Hungary

The following sections give a brief summary of the main findings of empirical studies, according to the areas of research presented in Table 4.1: the scale of informal payments, the determinants of informal payments, impact of informal payments on equity, policy options and motivation of the actors.

²⁸ He argues that lower social classes may deliberately overstate informal payments to show themselves part of a higher social class. Indeed, this motive ("other patients disdain those who do not pay") has been documented in the TK study [79].

4.3.1. SCALE OF INFORMAL PAYMENTS (EXTENT, MAGNITUDE, DISTRIBUTION)

The findings of quantitative studies which addressed the extent and magnitude of informal payments are summarised in Table 4.3 (bold figures in shaded cells), along with expert estimates from both national and international sources (non-shaded cells). The overall extent and magnitude of informal payments are available only from seven studies, which, in addition to the aforementioned limitations, are too sporadically distributed across the 30-year period to permit far reaching conclusions. There are other studies though, which also addressed the scale of informal payments and would help to complement the available evidence, but unfortunately there is insufficient detail in study reports. Nevertheless, the available evidence is sufficiently conclusive to draw some basic conclusions.

4.3.1.1. Overall extent and magnitude

There is evidence that informal payment is prevalent and, despite more than a decade of health care reform, still an issue in the Hungarian health care system (Table 4.3). According to the most recent TÁRKI study more than one-third of all patients, who utilised health services paid physicians and other health workers informally in 1998 [214]. The same study estimated informal payments as HUF 33 billion²⁹ (24-42 billion at 95%CI), which amounted to 4.8% of total expenditures on health. Nevertheless, findings on the overall magnitude of informal payment are inconclusive, especially if we consider expert estimates as well (Table 4.3). For instance, the KSH hidden economy study estimated the total amount of informal payment for health care to 3 billion HUF in 1997, which is approximately one-tenth of the estimate of the TÁRKI-1998 study, in real terms. Conversely, Balázs's guestimate for 1997 is more than 50% higher than that in real terms. Or the GKI's household survey in 1986 came up with a figure that is exactly half of the guestimate of Losonczi and less than one-third of the guestimate of Gyetvai and Szabó for the same year, and so on for 1992 and 1994. Most interestingly, the World Bank even published two different expert estimates for the same year, 1989 (Table 4.3). What is conspicuous though from Table 4.3 that guestimates are consistently and considerably higher than survey data, which corresponds well with the general opinion that informal payments 'must be' a significant component in health care financing in Hungary.

²⁹ This is equivalent to €137 million and US\$ 154 million at annual average exchange rates in 1998: 1 EUR = 241 HUF, 1 USD = 214 HUF [23,19.21].

Table 4.3. Extent and overall magnitude of informal payment in Hungary

Year	Research (er)	Extent (% of utilisers)	Magnitude (in million HUF)		Remarks / Source
			current prices	constant prices (1969=100)*	
1952	Ádám	-	48	12	<ul style="list-style-type: none"> expert opinion on the basis of period documents [49]
1969	OTKI	?	711	100	<ul style="list-style-type: none"> money & gift; only physicians included [77]
1973	DOTE	25%	620	79	<ul style="list-style-type: none"> only money; only physicians included 19.6% refused to answer [190]
1981	Petschnig	-	3,150	268	<ul style="list-style-type: none"> 2,300-4,000 [85; on the basis of 77; 190; 78, and own investigation]
	Ékes (GKI)	-	4,500	383	<ul style="list-style-type: none"> 4,000-5,000 [232; 200]
1984	Levendel	-	4,000	275	<ul style="list-style-type: none"> [195]
1985	Ékes	-	3,750	241	<ul style="list-style-type: none"> 3,500-4,000 [200; on the basis of 83]
1986	GKI	55%	2,000	122	<ul style="list-style-type: none"> only money; all health workers included [200]
	Losonczi	-	4,000	243	<ul style="list-style-type: none"> [109,p.123]
	Gyetvai, Szabó	-	7,000	426	<ul style="list-style-type: none"> 6,000-8,000 [233,p.145]
1989	WB	-	12,000	496	<ul style="list-style-type: none"> [cited in 203]
	WB	-	10,300	425	<ul style="list-style-type: none"> constant 0.6% of the GDP [112]
1990	WB	-	12,500	401	<ul style="list-style-type: none"> [112]
1991	WB	-	14,900	354	<ul style="list-style-type: none"> [112]
1992	SZGTI	14%**	7,300	141	<ul style="list-style-type: none"> gratitude payment; all health workers incl. [223]
	WB	-	17,300	334	<ul style="list-style-type: none"> [112]
1993	WB	-	21,500	339	<ul style="list-style-type: none"> [112]
1994	SZGTI	13%**	7,407	98	<ul style="list-style-type: none"> gratitude payment w/o explanation excluding non-disease utilisation, outpatient cases w/o sickness leave, private practice in public institutions [75]
	WB	-	26,200	348	<ul style="list-style-type: none"> [112]
1995	WB	-	33,700	349	<ul style="list-style-type: none"> [112]
	Kapócs	-	10,000	104	<ul style="list-style-type: none"> 5,000-15,000 [234]
1996	WB	-	41,400	347	<ul style="list-style-type: none"> [112]
1997	KSH	13%**	3,028	21	<ul style="list-style-type: none"> gratitude payment; all health workers incl. [225]
	Balázs	-	45,000	319	<ul style="list-style-type: none"> 40,000-50,000 [73; on the basis of 229]
1998	TÁRKI	36%	33,000	204	<ul style="list-style-type: none"> gifts & money; all health workers included [214]

Notes: *Applying CPI deflator; **% of respondents not of utilisers

Experts usually consider surveys underestimating the overall magnitude of informal payment [e.g.207; 235], while researchers usually think the same about their own findings [e.g.77; 78; 200; 223; 225; 214].

Research which tried to address the magnitude of informal payment by asking physicians proved to be unsuccessful in eliciting valid information, although in the TÁRKI-1992 study 52% of the respondents confessed that they accepted informal payment [229]. In contrast, when physicians were asked in the TÁRKI-1998 study, they thought that 79-94% accepted informal payments, depending on specialty, and that only 20% of physicians did not receive informal payments at all [214,pp.18-19].

Concerning trends, Galasi and Kertesi [202] analysed the results of five studies between 1969 and 1985.³⁰ They found a steady rise both in the extent and amount of informal payments during this period. Since then no such trend is discernible (Table 4.3), but inferences on the pattern and dynamics of changes is limited as it is difficult to assess how much change from one year to the next is real and how much due to methodological differences.

4.3.1.2. Distribution

The available evidence on the distribution of informal payment between different health workers is more conclusive. We have summarised findings concerning three service attributes: physicians versus other health workers (Table 4.4), levels of care (Table 4.5) and types of services (Table 4.6).

The distribution of informal payments has been uneven in terms of all three service attributes, which suggests that informal payments are concentrated in the hands of a relatively small group of health workers.

First, the OTKI-1972-73, KSH-1997 and TÁRKI-1998 studies are remarkably consistent in that medical doctors receive about 90% of the total sum of informal payments, while the much larger group of other health workers share the rest (Table 4.4). Second, the extent and the amounts are highest in hospitals and lowest in outpatient specialist care, with primary care somewhere in the middle (Table 4.5). According to the OTKI-1969 and TÁRKI-1998 studies this means that specialists collect approximately two-thirds, while family doctors one third of the 90% of informal payments that go to physicians. Furthermore specialists who work exclusively in

³⁰ OTKI-1969,1972-73,1981,1984 and TK-1985. In order to increase the comparability of research findings, the authors used the data for hospitals and for Budapest only.

inpatient care are considerably better off than those in independent polyclinics or dispensaries offering specialist outpatient care only (Table 4.5).

Table 4.4. Distribution of informal payments in Hungary: Physicians and other health care workers

Year Study	Extent (% of givers among utilisers)			Magnitude (in HUF/respondent)			Physicians' share (%)	Source Remarks
	Physician	Nurse	Other	Physician	Nurse	Other		
1972/73, OTKI								[78] excluding non-respondents
hospital (money)	37%	36%	24%	197	25	6	87%	
hospital (gift)	15%	25%	9%	?	?	?	?	
1984, OTKI								[201]
hospital	50%		41%	?		?	?	
outpatient sp.	?		?	?		?	?	
primary care	?		?	?		?	?	
1985, TK								[79]
hospital	?		?	?		?	?	
outpatient sp.	?		?	?		?	?	
primary care	?		?	?		?	?	
1992, SZGTI	?		?	?		?	?	[223]
1997, KSH	?		?	737		46	94%	[225]
1998, TÁRKI								[214,p.30]
hospital	?		?	6,122		756	89%	
outpatient sp.	?		?	477		54	90%	
primary care	?		?	218		29	88%	

Table 4.5. Distribution of informal payments in Hungary: Levels of care

Year Study	Extent (% of givers among utilisers)			Magnitude (in HUF/respondent)			Share of specialist care (%)	Source Remarks
	Primary care		Outpatient specialist care	Hospital (inpatient care)				
1969, OTKI	22%	61	11%	12	46%	88	62%	[77] only physicians
1972/73, OTKI	-	-	-	-	44%	197	-	[78] only physicians
1973, County Hospital Eger	-	-	-	-	30%	-	-	[80] only physicians
1981, OTKI	48%	?	57%	?	64%	?	?	[81]
1984, OTKI	18%	?	33%	?	55%	?	?	[201]
1985, TK	12%*	?	9%*	?	19%*	?	?	[79]
1996, TÁRKI	22%	-	-	-	?	?	-	[216]
1998, TÁRKI	26%	1181	15%	778	59%	1837	69%	[214,pp.14,29] /13-month period

Notes: *% of respondents not of utilisers;

Third, informal payments are unequally distributed in terms of actual health services, suggesting that specialists do not enjoy an equal share of the amount given in hospitals (Table 4.6). The OTKI-1984 study found that 69.1% of hospital patients paid

informally for delivery, 61.4% for operations, 50.4% for ‘conservative’ treatment, 47.8% for medical investigation (check up), 45.5% in the case of injuries and 31.7% for all other causes of hospitalisation. These findings have been supported by the TÁRKI-1998 study, which asked respondents about the usual amount of informal payments for certain services, and by the TK-1985 study, also providing information about average ‘tariffs’. Operations and deliveries are not only the most frequently ‘remunerated’ services, but also the most ‘expensive’. In contrast, diagnostic services are rarely paid for informally, according to the TÁRKI-1998 study (Table 4.6). These findings correspond well to views of physicians’ and the public about non- and best-paying medical specialties. In the TK-1985 study the general population were asked to rank medical specialties according to the amounts physicians received [79]. Not surprisingly obstetrics and gynaecology was ‘voted’ first, surgery second, internal medicine third and family medicine fourth. The TÁRKI-1998 study asked both the lay public and physicians, obtaining ranking that exactly coincide with the finding of the TK study [214]. However it is interesting to note that physicians consistently estimated the lowest frequency of informal payments in their own specialty. This phenomenon was also observed by Szabó [83] in the SZEKI study.

Table 4.6. Distribution of informal payments in Hungary: Services

Service type	Extent (% of givers among utilisers (share among all paying patients))				Magnitude (in HUF/utiliser (/all utilisers))			
	OTKI-1984 [201]				TK-1985* [79]		TÁRKI-1998* [214,p.13,26]	
Delivery	69%	(16%)	?	(?)	-	1,200	92%	11,000
Operation	61%	(36%)	?	(?)	-	1,300	-	-
- tonsillectomy	-	(-)	-	(-)	-	-	77%	3,500
- appendectomy	-	(-)	-	(-)	-	-	87%	6,000
- open heart surgery	-	(-)	-	(-)	-	-	92%	29,000
Hospital check-up	48%	(14)%	?	(?)	-	310	-	-
Family physician visits patient at home	-	(-)	-	(-)	-	140	75%	1,600
X-ray	-	(-)	-	(-)	-	-	8%	130
Measuring blood pressure	-	(-)	-	(-)	-	-	12%	60

Notes: *Respondents’ opinion

There are no quantitative data available on the association of informal payments with other service attributes, such as the geographical location of the institution and the

health workers' position in the hierarchy.³¹ With respect to the former, the place of residence of patients can be used as a proxy, which will be analysed in the next section,³² while we have some data from SZEKI-1983-84 and the TÁRKI-1998 studies regarding professional status and related factors. According to the SZEKI-1983-84 study, physicians think that higher position in the hierarchy implies more 'paying' patients offering larger amounts [83]. For instance, one physician commented that: "...There is a very sophisticated mechanism of patients' selection everywhere, that is why the junior doctor gets, for instance the gypsy woman". This view is supported by the TÁRKI-1998 study. Physicians ranked 'position' as the second most important factor influencing the amount of informal payments, immediately after specialty and before 'fame' and 'assertiveness' [214,p.20]. It is interesting to note that only one-third of medical doctors mentioned performance, which fits the finding of the SZEKI-1983-84 study that so-called "*pretence-activities*" mattered more [83].

4.3.1.3. Conclusions

Is the available evidence on the scale of informal payments sufficiently conclusive to regard the phenomenon as an important health policy issue? The findings reviewed here suggest that informal payments are indeed widespread in the Hungarian health care system. For instance, the findings of the most recent TÁRKI study reporting an overall frequency of 36%, with 59% of 'paying' patients in hospitals, indicate a much higher level than the 1.6% of respondents admitting making small gifts to health workers reported by Masopust [218] in the North Bohemian region of the Czech Republic (Czechoslovakia), but comparable with Poland, where in a national representative survey by Chawla et al. [204] found that 69% of the patients in non-regional and 61% in regional hospitals made "*envelope payments*" to physicians, and with Bulgaria, where Delcheva et al. [74] found that in the two years prior to their national survey, 43% of the respondents had paid for health services that were officially free of charge.

³¹ Analysing the results of 4 studies (OTKI-1984;TK-1985;SZEKI-1983-84;GKI-1986) Ádám [8,pp.138-164] has found that "*medical gratitude payment*" is associated with the medical speciality, the location, type and level of the institution and the doctor's position in the hierarchy. However, for most of the above factors there are no such data available in the cited studies. For instance the location of the institution has not been included in any of these studies, he probably drew his conclusion from the data on the place of residence of the payers. Not denying the association between the two factors, they are not the same.

³² It must be noted that the variables, which are discussed here as factors which influence the distribution of informal payments are the same as the variables, which are conceptualised as one group of variables (referred to as service attributes) that determines the alternative behavioural options and are discussed in the next section.

Nonetheless, the frequency of giving, in itself, does not indicate that the overall sums are substantial. The evidence of the overall magnitude of informal payments in Hungary is inconclusive and contradictory, with an order of magnitude difference between the highest and lowest survey estimates (Table 4.3). One can argue, though that even the highest survey estimate (TÁRKI-1998) is far below the level reported from countries of the FSU and even some other CEE countries. The estimated HUF 33 billion [214] is still less than 5% of total expenditures on health in Hungary, while according to Lewis [96,p.19], informal health expenditures make up 84% of all national health expenditures in Azerbaijan, 56% in the Russian Federation and 30% in Poland.

The aggregate total is not, however, the key factor. It is the distribution of informal payments that matters more. There is conclusive evidence from Hungary that health workers benefit unequally of informal payments. Physicians receive the bulk of these payments, especially certain specialists, including obstetricians and surgeons who work in inpatient care, as well as family doctors. We argue that to establish the policy significance of the phenomenon, we must conduct an in-depth analysis of the relationship of informal payment to salary for the various groups of health workers. For instance, Chawla et al. [204] found, in Poland, that distributing envelope payments equally among all health workers in general hospitals gave each individual an additional income of 10% of their gross salary. In contrast, considering only physicians, who received 81% of the total amount, each took home more than double of their gross salary in informal payments.

Thus, the scale of informal payments needs further consideration. Since many of the data collected in previous studies have yet to be fully analysed (OTKI-1981,1984; TK-1985; SZGTI-1992; TÁRKI-1996), additional secondary analysis seems to be a rational first step.

4.3.2. DETERMINANTS OF ALTERNATIVE BEHAVIOURAL REACTIONS

Let us now consider what the empirical literature says about the factors that influence choice of the various behavioural responses (with willingness to do as the dependent variable), with the focus on inxit. We have categorised the potential independent variables into three main groups: personal attributes (e.g. age, gender, family status, socio-economic status), behavioural attributes (e.g. attitudes, perceived legality and legitimacy) and service attributes (e.g. levels of care, location of the institution, position, specialty, service types). We have already discussed service attributes in the section about the distribution of informal payments so here we focus on the first two.

Exploration of associations between informal payments and individuals’ various characteristics could capture the ‘coercion factor’ in giving. In particular, we are searching for evidence that allows us to distinguish the associations between informal payment and personal attributes from those directly attributable to service characteristics. We have argued that if informal payments are similar to a donation then the amount paid by patients should exhibit substantial variations even in the same health care institution for the same service, provided by the same physician. However, there are certain personal attributes that are correlated with service attributes, such as place of residence and the location of the health care institutions. The analysis of their relationship requires that both are addressed within the same study.

4.3.2.1. Personal attributes

Most of the studies addressing informal payments have recorded the basic demographic features of respondents (including age, sex, occupation, education, place of residence). The published findings, presented in Table 4.7, show remarkable consistency, but unfortunately few publications went beyond a simple univariate analysis. So far the most detailed analysis of the association between informal payments and personal attributes of the givers (payers) comes from the OTKI-1972-73 study [78; 227].

Table 4.7. Determinants of informal payment to physicians (personal attributes)

Determinant	Association	Source
gender	women give more frequently	[78; 214]
age	women between 20-49 give most frequently	[78]
place of residence	+: larger settlement implies higher amounts, more frequently	[78; 200; 201; 75; 214]
level of education	+: higher level of education implies higher amount, more frequently	[78; 75] [83]
occupation	+: higher position implies higher amounts more frequently	[78; 190; 201]
income	+: higher income implies higher amount more frequently	[75]
health status (self-assessed)	-: healthier gives less frequently	[201; 75; 214]
health care utilisation	+: more visits to the family doctor implies more frequent payment	[201]
satisfaction with services	-: dissatisfaction implies more frequent payment	[227; 214]

Tóth et al. found a positive association between informal payments to physicians and gender, age, socioeconomic status (level of education, occupation) and place of residence of hospitalised patients while, interestingly, there was an inverse relationship with patient satisfaction (Table 4.7). For instance, the percentage of payers and the average amount per payer were found to be 24.6% and 504 HUF respectively in the

group who had completed fewer than 8 classes at school and 53.3% and 754 HUF in the group with higher education [78]. Other studies not only confirmed most of these associations, but identified other determinants, such as income [75].

Both the frequency and size of payments increase with the size of the settlement in which respondents live. For instance, according to the OTKI-1972-73 study, patients living in the capital, Budapest, paid almost twice as frequently as those living in villages (55.8% vs. 30.2%), and the average amounts per payer were 600 HUF vs. 477 HUF respectively [78]. This suggests that informal payments are unequally distributed between health workers in different regions, insofar as the respondents utilise health services at their place of residence. Unfortunately there is no published evidence on the location of the health care provider that would allow us to separate the two.

Tóth et al. [78] conducted a separate analysis of in-kind payments (gifts) and cash given to nurses. They found that the same factors were associated with each type of payment, but they examined only the frequency of giving. Among nurses, level of education, occupation and gender had the same effect on informal payments as with physicians, while place of residence was associated only with the frequency of giving and not the amounts paid.

Some studies addressed other relevant personal attributes such as trust in, knowledge of and opinion about health services (as in the TK-1985 study), but the correlation between the various factors associated with informal payments has hardly been considered. One exception is the OTKI-1972-73 study. Tóth et al. [78] found that level of education and place of residence were independently associated with informal payments. Among patients who lived in the same type of settlements, the more educated gave more frequently, while patients with the same level of education paid more frequently with increasing urbanisation.

4.3.2.2. Behavioural attributes

The TK-1985 study addressed two behavioural attributes, public attitudes and the perceived legality of giving and accepting informal payments [79]. It is interesting to note that the majority of respondents condemned informal payment (77% disapproved of giving, while 66% disapproved of accepting), and saw it the third most important problem facing the health care system.³³ Unfortunately, the authors did not analyse the association between attitude to payment and the frequency or amounts of payment.

Neither did they publish any findings concerning the perceived legality of the phenomenon.

4.3.2.3. Association with exit and voice

Nine studies have looked at both private sector utilisation and informal payment (OTKI-1969,1972-73,1981,1984; DOTE-1973; SZGTI-1992,1994; TÁRKI-1996; KSH-1997). The role of personal attributes in explaining exit resembles what is found with informal payment. Furthermore, there is some evidence that exit and inexit are associated. Petőné [190] found that those who utilised private health services more frequently paid informally in the public setting, a finding confirmed by the OTKI-1981 study [228].

Two studies addressed the issue of voice (TK-1985; TÁRKI-1996), however only the latter have been published so far. The voice option was found to be associated educational background, also linked with informal payments [216].

4.3.2.4. Discussion and conclusions

So is there sufficient evidence to support either the ‘donation’ or the ‘fee-for-service’ hypothesis? The empirical literature has established that informal payments are associated with both service and personal attributes, but the published findings are insufficient to determine which group of variables explain the variation in how much patients pay. The analytical problem is twofold. First, certain personal attributes, such as education, occupation and income, are correlated, but researchers rarely separate their effects on informal payments. Second, certain personal attributes could be correlated with service characteristics, which would then need to be distinguished. For instance wealthier patients may be more likely to seek physicians with a better reputation and hence who are more ‘expensive’. Similarly, any effect of living in an urban or rural settlement may be confounded by differing ‘fees’ of urban and rural health care providers ‘charge’. To test this hypothesis we must control for both groups of variables (personal and service attributes) within the same study. Unfortunately, the data in the two studies that recorded both the place of residence of respondents and the location of providers (OTKI-1972-73,1981) are not available for secondary analysis.

Nevertheless, the empirical literature does contain a few interesting findings that may help to clarify the motivation of actors. It seems that the association between dissatisfaction with services and informal payments is incompatible with the gratitude

³³ In the DOTE-1973 study Petőné [190] got to the same conclusion: “most respondents disagree with informal payments”. The exact proportion has not been revealed though.

payment concept [227; 214], reflected in the disapproving attitude of the overwhelming majority of people in the TK-1985 study [79]. Nonetheless, the association between attitudes and informal payments remained unexplored, as with other relevant factors, including trust in the system, knowledge and opinion about health services.

4.3.3. IMPACT ON EQUITY

Relating equity to the validity of the ‘donation’ hypothesis we have assumed that a disproportionate financial burden, as well as the resulting differential access would challenge the validity of the gratitude payment concept. Nonetheless, this is a topic that has rarely been addressed so far. Here we present the scant evidence available and provide a few examples that address the impact of informal payments, albeit requiring further analysis.

The TÁRKI-1996 study analysed factors that prevent people from visiting a doctor. Even though visits were free of charge, 11.7% mentioned that they delayed seeking assistance if they had a problem because of the cost. Furthermore it found that the frequency of giving informal payment was higher among those who saw the doctor early (those with no or mild symptoms) than those who visited the doctor later (with more serious illness, or a major problem). The author concluded that informal payment influenced the timing of utilisation, suggesting the existence of a financial barrier to entry [216]. This is not the only possible explanation, though, as reverse causality cannot be excluded with certainty.

Tóth et al. [78] found that more educated patients were more likely to be placed in smaller wards (assessed by numbers of beds). Similarly, the physician was more likely to hand the discharge note personally to more educated patients. Since the frequency of giving and the amount of informal payments have been found to be associated with patients’ level of education, these findings could reflect to the impact of informal payment. Another example comes from the OTKI-1984 study, where researchers found an association between the respondent’s occupation and the role of the hospital doctor in rehabilitation after discharge. Many of the studies also addressed other factors, for instance the type, number and length of discussions with physicians and nurses during the hospital stay (OTKI-1972-73), waiting times, information provided to the patient (OTKI-1981;TÁRKI-1996), sickness benefits (OTKI-1984; TÁRKI-1996), and number of home visits (TÁRKI-1996), but the data have not been analysed yet.

As we have discussed in chapter 3, patients' perceptions of the consequences of paying or not could be as important as the true impact of informal payment.³⁴ The TK-1985 study addressed this issue by asking people "*what they think would happen with those who do not pay*". Dobossy et al. [79] concluded that the overwhelming majority of respondents expected some sort of discrimination from health care staff; either poor service quality (57% of the respondents thought that the doctor would be impolite, 55% that would they be ignored by the nurses, and 52% that they would be kept waiting), or clinical quality (50% thought that they would be treated superficially), while only a small fraction of respondents expected disdain from fellow patients. This is in sharp contrast with the opinion of medical doctors, according to the SZEKI-1983-84 study. Most physicians thought that their standard of care was not influenced by informal payment, and only a small fraction (8%) saw substantial advantages accruing to those who paid, either in terms of service provided or clinical quality (free choice of doctor, shorter waiting times, rare and expensive treatment) [83].

4.3.4. POLICY OPTIONS AND POLITICS OF INFORMAL PAYMENT

In chapter 2 we have reviewed the wide-ranging health sector reform brought about by the collapse of the communist dictatorship in Hungary. Although considerable changes have been implemented in the organisation and functioning of the Hungarian health care system, I have not found any research (not even a single case study) that sought to evaluate the effect of reform on informal payments. The only exception is the historical analysis of Ádám [49; 8], but that addressed only the pre-reform period. His detailed retrospective account on the history of policy responses to informal payment has already been summarised in chapter 2.

Some studies sought the views of the general public, patients and physicians about what to do about informal payments (DOTE-1973;SZEKI-1983-84;TK-1985). For instance Petőné [190] found that 73% of respondents had some opinion about how the practice of giving informal payment could be abolished. Most (24.5%) saw the solution as increasing physician's salaries, others proposed tighter accountability, and some condemned patients for seeking inappropriate advantage. In the TK-1985 study only 35% of the respondents thought informal payment could be eliminated from the system. Among the possible options, 62% mentioned formal payments, 56% saw the solution as raising salaries of physicians, 47% as increasing the number of health staff and strengthening institutional capacity, while 38% suggested infrastructural developments.

³⁴ See the concepts of 'trust in the system' and 'perceived performance decline' in Chapter 4.

These options were more frequently mentioned by younger males. Others, mainly older people and those living in small settlements saw the solution in administrative measures, including punishment for accepting payment (63%), tighter control over physicians (56%), and educational measures such as the enhancement of doctors' sense of vocation (57%). Finally, 45% proposed the extension of private practice.

In the DOTE-1970 study, 50% of clinicians considered informal payment unethical and only 25% agreed with it, mainly the younger ones. In contrast two-thirds of the respondents thought gifts to be acceptable [82]. Furthermore Szabó [83] found that physicians had an ambivalent view about informal payment. They did not particularly like the system, but they needed the additional income to make ends meet: “... *informal payment is the curse and benefactor of the medical society*” as one of the physicians put it. Most of the doctors condemned the expectation of informal payment, but would have liked higher (2-3 times more), performance-related payment.

Evidence of the effectiveness of policies to address informal payment from other countries is rare in the English language literature. The Greek HiT profile reports that an increase in physicians' salaries decreased informal payments, but temporarily. The difference between the salaries of medical doctors and other public employees gradually diminished, leading to the re-emergence of informal payments [89]. In contrast, the OECD considered this experiment a total failure, achieving nothing [221]. Marée and Groenewegen [220] cite the former GDR as an interesting example of a former communist country where informal payment for health care was less of a problem. They attribute this to the relatively higher salaries of medical doctors, but it is not clear on what evidence they base this conclusion. The examples of the former GDR and Greece suggest that physicians' salaries play a key role in the initiation of informal payment, but once established simply raising pay is unlikely to eliminate it.

4.3.5. CAUSES AND PRECONDITIONS

In this section we ask whether informal payments existed before the establishment of the state-socialist system in Hungary and search for evidence of (common) features of health care systems that struggle with informal payments compared those that do not. So far the analysis of the causes of this phenomenon has been dominated chiefly by theoretical debates, with the exceptions of the historical analysis by Ádám [236; 237; 154; 238] with its focus on informal payments and Balázs [236; 237; 154; 238] which looked more widely at the remuneration of physicians. While Ádám unequivocally linked the emergence of informal payments with the state-socialist health care system,

Balázs claimed that the roots lay in the pre-war period. The main elements of both approaches have already been summarised in chapter 2. Comparative analysis of health care systems could provide further evidence, but to my knowledge no such research has been carried out so far.

4.3.6. MOTIVATION OF THE ACTORS

As we have argued previously, it is ultimately the intentions of patients and physicians that determine whether informal payments are truly voluntarily or are forced, in a wider sense, regardless of their actual impact on patient care. In this section we present evidence that claims to reveal the true motivation of the actors, either directly or indirectly.

First, we focus on whether gratitude is, and to what extent, a real motivating factor. The empirical literature about the principal motivation of the actors relates to the two participants in the transaction, with various research questions about each of them (Table 4.8).

Table 4.8. Exploration of the principal (stated/revealed) motivation of participants

Stated motivation	Research question /addressed in
Motivation of patients as seen by the:	Why do patients give informal payment?
• payers themselves	Why did those pay who actually gave? OTKI-1972-73,1981; County-Hospital-Eger-1973; DOTE-1973 [78; 81; 80; 190]
• people in general	What do the people think about why people give? TK-1985 [79]
• doctors	What do the doctors think about why people usually give? SZEKI-1983-84 [83]
Motivation of doctors as seen by the:	Why do doctors accept informal payment?
• doctors themselves	Why did those who accepted it actually accepted it? DOTE-1970; SZEKI-1983-84 [82; 83]
• doctors in general	What do the doctors think about why doctors accept it? Not addressed in any studies
• people	What does the patient think about why doctors accept it? Not addressed in any studies

Second, in the empirical literature we have identified satisfaction with services (and with the workplace), the timing of the transaction (before and after), attitude towards informal payments, stated willingness to pay for services and trust in the system (what happens if someone does not pay?), as factors that can help understand whether people honestly reveal their true intentions about informal payments in surveys. For instance, it is incompatible with the gratitude motive if patients pay before receiving the service.

Similarly, it is very unlikely that patients who believe that physicians have not provided adequate care in the absence of informal payments will pay purely to express their gratitude.

4.3.6.1. The stated motivation of patients

Tables 4.9 and 4.10 summarise the published findings on motives revealed by patients and, in the case of the TK-1985 study, the general population. Unfortunately the data collected in these studies have not been fully analysed. Many of the papers present only broad rankings and the findings of the TÁRKI-1996 study have not been published at all.

It is conspicuous that the various findings are inconclusive and contradictory. By and large the empirical literature assesses four main motivation categories: gratitude (in the TK-1985 identified with patient satisfaction), custom and practice, better care (in general or for specific services, such as rare and expensive treatment, home visits or more thorough examination) and enforcement by providers. There are, however, some other factors such as *“the low salary of physicians”* and *“psychic security”*, which are mentioned only in the TK-1985 study.

While the OTKI-1972-73, County-Hospital-Eger-1973, and OTKI-1981 studies have found gratitude to be the single most important motivation of patients, the OTKI-1969 study did not mention gratitude at all, and it is the least important factor in the DOTE-1973 and TK-1985 studies. According to physicians in the SZEKI-1983-84 study real gratitude is rare as a motivating factor.

Findings concerning the issue of ‘want for better care’ reflect exactly the same contradiction. While the OTKI-1969 and TK-1985 studies have found that patients primarily pay to ensure good quality care or certain ‘special’ services, this motive is less important in the OTKI-1972-73 and 1981 studies, and the County-Hospital-Eger-1973 study did not even mention it. Petőné [190] has placed it between ‘customary’ and ‘gratitude’ in the DOTE-1973 study.

One form of enforcement is when informal payment is the result of expectation created by health care staff. In the empirical studies reviewed this appears as either *“expectation”* (OTKI-1972-73, 1981), or the more direct *“enforcement”* (TK-1985), while in the County-Hospital-Eger-1973 study Csapó [80] operationalised it as *“the doctor called your attention [to give]”*.

Table 4.9. Findings of empirical research on patients' motivation in Hungary

Ranking	Motive						Frequency of responses (%)			
	OTKI-1969 [77]		OTKI-1972-73 [78]		County-Hospital-Eger-1973 [80]		DOTE-1973 [190]		TK-1985 [79]	
1	better care	vast majority	gratitude	66	gratitude	85	customary	?	better care (safe recovery)	87
2	customary	small fraction	customary	13	other patients suggested	3	better care	?	psychic security	75
3			expected	11	relatives recommended	1	gratitude	?	thorough examination	65
4			better care	6	doctors called my attention	1			rare & expensive treatment	54
5			only this way could get good care	3	more than one	10			modern diagnostic equipment	43
6			more than one	2					enforced	40
7									low salary of doctors	37

Table 4.10. Findings of empirical research on patients' motivation in Hungary: levels of care

Ranking	Motive						Frequency of responses (%)					
	Hospital (inpatient care)		Outpatient specialist care		Primary care		Hospital (inpatient care)		Outpatient specialist care		Primary care	
	OTKI-1981						TK-1985 [79]					
1	gratitude	55	gratitude	44	gratitude	48	distinguished treatment	30	distinguished treatment	11	home/night visit; accepting outside surgery hours	60
2	expected	14	expected	24	expected	17	serious illness	25	regular treatment	7	sickness benefit	19
3	customary	14	better care	21	better care	12	satisfied (gratitude)	19	sickness benefit	5	distinguished treatment	11
4	better care	8	customary	6	customary	10	hospital admission	6	satisfied (gratitude)	3	satisfied (gratitude)	3
5	other	8	other	6	other	9						

Findings on the importance of provider coercion are equally inconclusive, even if we take into account how changes could have occurred over time. While it was the second and third most important motivation factor according to the OTKI-1981 and 1972-73 studies, it was among the least important factors in the TK-1985 and the County-Hospital-Eger-1973 studies. Moreover the OTKI-1969 and DOTE-1973 studies did not mention it at all. In the OTKI-1970 study hospital patients considered provider coercion as the most problematic aspect of inpatient care [226], while the more recent SOTE-1995 study found it the third most important complaint about health services [224].

The conceptually most ambiguous category is the fourth one, summarised as ‘it is customary to give’, which lies between ‘gratitude’ and ‘coercion’ according to our interpretation. Petőné [190] identified this as the most important motivation in the DOTE-1973 study, while Tóth et al. [78] found it to be the second most important after gratitude in the OTKI-1972-73 study. It also appeared in the OTKI-1969 and 1981 studies, but among the least important factors, while the TK-1985 study did not even mention the concept. Interestingly, physicians considered ‘custom’ as the most widespread motive of patients, along with *“the fear of not getting adequate care”* according to the SZEKI-1983-84 study [83].

However, the most important problem within this category is not the inconclusiveness of the findings, but that it is unclear what researchers meant by ‘customary’ and whether it is conceptually justified to treat it as a separate category. Is it part of the ‘donation’ explanation or is it a special form of coercion, a *“society wide pressure”* as one physician put it in the DOTE-1970 study [82]?

Indeed, the OTKI [228] paper has raised the idea that there is an overlap between ‘gratitude’ and ‘custom’, as it might not be easy to distinguish whether people are really grateful or have ‘learnt’ that they should be grateful. However, we argue that this interpretation rather supports a possible overlap with ‘coercion’ categories of ‘better care’ and ‘enforced’, since when people have learnt that they ‘should’ do something it is not truly voluntary. In the County-Hospital-Eger-1973 study, this aspect of custom emerged more clearly. Csapó’s [80] ‘other patients or relatives recommended’ refers to the pressure from others, which is also discoverable in the motive of ‘paying, because others pay as well’, and the ‘disdain of other patients’ as a consequence of non-payment in the TK-1985 study [79]. Although Dobossy et al. [79] did not explain what they meant by their ‘psychic security’ motive (the second most frequent in their study), it is possible that these kinds of external pressures underlie anxiety of patients that could be

reduced with informal payments. The findings of the SZEKI-1983-84 study could offer another plausible explanation that brings ‘customary’ even closer to the ‘coercion’ form of motive. In this study, physicians considered the patients’ fear of ‘what happens if they do not give’ as an important motivating factor as well as it being customary to give [83]. While the authors of the OTKI-1981 study pointed out the difficulties of drawing a clear border between gratitude and custom, we argue that it is equally difficult to find a sharp border between custom and expectation (coercion). It is possible that behind the custom of giving informal payment is “*a society wide pressure*” [82], which could be identified as the “*fear of the consequences*” of non-payment, which could well be the consequence of a general distrust that the provider will deliver adequate care, as we have argued in chapter 3. This distrust can be created by a real or perceived decline in quality. This line of thought suggests that, in terms of the donation hypothesis, the real difference in motivation lies between gratitude and the various forms (continuum) of expectation, whether the source lies in society in general (loss of social capital), specific groups (patients, relatives, friends), or health care staff.³⁵

Nonetheless, this speculation still does not resolve the conflict between those studies in which gratitude was found to be the most important motivation of patients (OTKI-1972-73; County-Hospital-Eger-1973; OTKI-1981) and those that arrived at the opposite conclusion (OTKI-1969; TK-1985).

4.3.6.2. Discussion

So is it possible to explain these contradictory findings? We have to consider the differences in study designs, including timing, study population, sampling, response rates and method applied. One of the most important issues though is how motivation and motivating factors are conceptualised and operationalised in the various surveys.

In the case of closed questions, the options offered could influence the answers. By leaving out certain options, researchers may lead respondents (as in the County-Hospital-Eger-1973 and TK-1985 studies). Moreover, the various categories should be valid, distinct and exclusive. Researchers should have ensured that there was a shared understanding of what the various options meant, and that these options did not overlap, a possible problem of the OTKI-1972-73, 1981 and DOTE-1973 studies. By using open questions to supplement a closed question, Dobossy et al. [79] has overcome this problem, but in this case the coding of answers has to be conceptually sound. The

³⁵ In the context of our study, however, we assumed that it was a ‘non-coercive’ motive, in order to be on the ‘safe side’.

findings of the TK-1985 study provide a good illustration of these operationalisation problems. While in the closed question, 'gratitude' was not offered as an option, it came out as a response from the open questions (Tables 4.9,4.10). The data collected in the TÁRKI-1996 study could have yielded evidence to clarify this issue, insofar as researchers used the same coding scheme as Tóth et al. in the OTKI-1972-73 and 1981 studies, but the question itself was open, giving respondents the chance to express their own thoughts, using their own words. Unfortunately these findings have not been reported in the paper.

Further, there is evidence from the County-Hospital-Eger-1973 study that surveys alone may not be able to capture the true 'gratitude' motive. Csapó [80] found that in 10% of cases gratitude was mentioned in combination with another, 'coercive' motivating factor, which in theory were mutually exclusive. This indicates that the concept of gratitude has diverse interpretations, or raises the possibility that people might rationalise their decisions after the event if they consider enforcement embarrassing and unacceptable. They resolve the conflict by believing that they gave voluntarily to express their gratitude.

At the same time we should not forget that the question itself is sensitive, insofar as people consider it illegal or illegitimate to expect enhanced services in exchange for payment. This suggests that we must assume selection bias, especially where response rates are low, and respondent bias, perhaps in the form of citing gratitude as what is perceived to be the most legitimate motive. This could explain the large differences between the findings of the OTKI-1972-73, 1981 and the TK-1985 studies. Moreover, these studies differed in terms of study populations. While the OTKI-1972-73 and 1981 studies targeted those who actually paid, the TK-1985 study sought views from the general public. It is not unreasonable to assume that most people feel gratitude towards the medical staff if they were cured from a serious illness, but the feeling of gratitude does not necessary mean that it is the principal motivation for informal payment. It could be that the measurement of motivation partly captured the gratitude that the person felt after the treatment rather than the 'true' motivation.

Nonetheless, changes in the motivation of participants cannot be excluded with certainty. The huge difference between the findings of OTKI-1972-73 and TK-1985 studies might well be attributed to the 13-year time lag between the two studies. This is less likely to be the case, though, concerning studies, which were implemented close to each other in time, such as studies of OTKI in 1969 and in 1972-73, and the OTKI-1981

and TK-1985 studies. Thus, the contradiction between available studies remains an issue that is as yet unresolved.

The analysis of the association between stated motivation and other factors, such as satisfaction and willingness to pay, might help to clarify the validity of the various categories. Unfortunately, analysis of this kind is very rare and often omitted from publications. In the next section we will review what is known.

4.3.6.3. The association of motivation with personal and service attributes

Stated motivation was found to be associated with the level of care (Table 4.10), gender [226; 78] and education of the respondents [78]. Researchers have found that men cite gratitude more frequently, while the less educated cite 'coercive' motives. Otherwise, the published findings are very limited. For instance Tóth et al [77], Csapó [80], Petőné [190] and Dobossy et al. [79] did not present any findings on this issue.

4.3.6.4. Motivation and stated willingness to pay

One approach could be to ask about 'willingness to pay' for various services rather than to ask specifically about informal payments. This may be less sensitive than mentioning informal payment directly, but still asks people about their own intentions and not their opinions about the views of others. However, its methodological weakness lies in the difference between how people actually behave and what they say would do in a hypothetical scenario, especially if people suspect that an agenda promoting 'future charges' lies behind this kind of question.

Table 4.11. Willingness to pay for health services in the general population in 1985 in Hungary

Service	Percentage of respondents
Operation is done by the best surgeon	67%
Free choice of doctor	51%
Rare, expensive medication	48%
Up to date diagnostic equipment	48%
To be served more quickly concerning important examinations	40%
To get hospital admission when it is most convenient	39%
Distinguished, especially good care	38%
GP always provides service at the home of the patient	33%
One or two-bed ward in the hospital	28%

Source: [79, N=1,000]

Three studies addressed stated willingness to pay for services: TK-1985, SOTE-1995 and TÁRKI-1996, although only findings of the TK-1985 study have been published (Table 4.11). Even in this latter study, the data collected remained largely unanalysed. On the other hand the SOTE-1995 study found that 39% of the general population

would have been willing to pay to replace informal payments. Unfortunately this is not a particularly useful finding for our purpose, since the study did not address motivation to pay informally.

4.3.6.5. Before and after

The timing of informal payments is important inasmuch as payment after the service is a defining characteristic of the gratitude payment concept. The County-Hospital-Eger-1973 and the TK-1985 studies addressed this issue, but only the former provided data that can be analysed for our purpose.

Csapó [80] found that 30% of those who paid gave before (17%) or during (13%) the treatment, while 86% stated that they gave to express gratitude. Although it is not possible to find out from the publication who paid before or during the treatment among those who were motivated by gratitude, from the available information we can conclude that there must have been an overlap between the two (of at least 16%). This is true even if we consider only those who paid beforehand (a minimum of 3%). Paying before to thank for the service, however, is a conceptual nonsense. This suggests that the concept of gratitude as a motivation factor is not so straightforward in practice as in theory.

4.3.6.6. Trust in the system

As we have argued in chapter 3, distrust that the health care system will deliver adequate services can be an important factor in the initiation of informal payments. It is unlikely that patients who do not trust in the system will pay physicians informally because of gratitude. There are a few pieces of evidence that suggest that trust is indeed an important factor, but unfortunately researchers have not related these findings to the issue of motivation.

We have already mentioned that Dobosssy et al. [79] posed the question of ‘what happens with those, who do not pay’ in the TK-1985 study, and the majority of respondents expected some sort of discrimination; that ‘psychic security’ was the second most frequently mentioned motive for informal payments in this study; and that in the SZEKI-1983-84 study physicians regarded ‘fear of consequences’ as one of the most important reasons of why patients pay [83]. Other studies examined the reasons for private sector utilisation (exit). Tóth et al. [77] have identified ‘higher confidence’ in private physicians (47%) as the most important motive for seeking private care, while it was also mentioned in the DOTE-1973 study [190]. The OTKI-1981 study suggests that the perception of not getting proper treatment is a more important factor in seeking

private care than the kindness of the physician. The MTA-SZKI-1988 study identified how one component of the fear and anxiety that accompanied delivery was the fear of not getting appropriate care, which was six times higher in less educated primipara than among those with higher education qualification [217,pp.74,96]. Moreover, 66% of primipara planned to hire a private doctor for the delivery, while 33% had already done so during the pregnancy [217,p.95]. Finally, there is evidence that trust is a relevant issue in other countries struggling with informal payments. Lewis [96,p.18] reported the findings of a survey in the Russian Federation where 25% of respondents utilised private care because *“they lacked confidence in the professional qualifications of public health physicians”*.

4.3.6.7. Other factors

There are a number of other factors, previously mentioned, whose association with patients' stated motivation could facilitate testing the validity of the 'gratitude' motive. For instance, purely voluntary payment is unlikely by people who disagree with informal payment, who advocate its elimination, or who are dissatisfied with the care they receive. Unfortunately these issues have not been explored in the existing studies.

4.3.6.8. The stated motivation of service providers

There is very little evidence about the motivation of physicians. Petőné [82] carried out a survey among university physicians while Szabó [83] conducted in-depth interviews with 100 specialists working in inpatient care. Their findings are summarised in Table 4.12. Unfortunately Petőné's publication does not contain exact figures, but she states that the most frequently mentioned motivation for accepting payments is 'low salaries', which corresponds with the finding by Szabó. Enhanced performance (15%, exceptionally here the figure is provided) was only the fourth most often cited reason after 'low salaries', 'refusal would offend the patient' and 'it is customary'. The analysis does not, however, go further than this.

Szabó [83] provides many fascinating qualitative findings about the acceptance of informal payments. While most doctors cite low salaries as the most important factor, the story of how willingness to accept payment develops over time shows the role of other 'minor' pressures. These come from patients who become upset if 'gifts' are refused or from colleagues whose business is 'damaged by the aberrant physicians'.³⁶

³⁶ This expression is from one of the interviews I conducted with medical doctors, but it very much matches with the findings of Szabó [83], even if she does not use these words.

4.3.6.9. Conclusions

Is it possible to determine what motivates giving and accepting informal payments? The main conclusion is that evidence from empirical studies is contradictory and cannot be explained simply by changes over time. There seems to be an issue of validity of questions used to assess some potential motivation factors, but the diverse methods used to operationalise the concepts make it difficult to assess where the problem lies. Unfortunately, many analyses from empirical studies that could contribute to the understanding of the problem remained unpublished. Nevertheless, the available evidence raises the possibility that surveys alone are not sufficient to capture the real motivation of patients.

4.4. Overall conclusions from empirical research

At the beginning of this chapter we formulated research questions and generated corresponding hypotheses that were derived from the ‘donation’ explanation. Although several studies have dealt with the topic of informal payment, the available evidence is insufficient or inconclusive with regard to the validity of the gratitude payment concept.

Informal payment is widespread in the Hungarian health care system and it is concentrated in the hands of a relatively small group of health workers (mainly specialists working in hospitals). However evidence about the overall magnitude of informal payments is contradictory, with the highest and lowest estimates varying by an order of magnitude. Hence, we have not been able to quantify the importance of the issue with certainty, but it is also true that not all the available data have been fully analysed.

Findings concerning the motivation of actors are equally contradictory, and those factors (such as attitudes towards informal payment and satisfaction with services) which could have helped to clarify the picture have remained largely unexplored. Further, the determinants of informal payment and their inter-relationships have not been explored adequately.

Evidence is most limited in relation to the impact of informal payments on equity and on policy options that might tackle the issue. Neither question has really been addressed so far.

Adequate evaluation and interpretation of empirical evidence cannot be complete without considering the methodological and contextual limitations of previous research. First, empirical research on informal payments in Hungary embraces a 30-year period, so that most studies are outdated. Second, a major problem is the lack of a common

framework (the definition and operationalisation of informal payment and motivation factors, etc.) which makes the results of the various studies difficult to compare. Third, the external validity of the results is questionable in many cases, because of the choice of study population and low response rates. The sensitivity of the issue makes the various studies prone to respondent bias, and we have limited knowledge about the effect of the various study designs on responses.

Finally it is conspicuous from this review that many relevant data remain unanalysed or unpublished. This highlights the importance of secondary analysis of available databases a necessary first step in the present study.

CHAPTER 5.

5. RESEARCH QUESTIONS AND METHODS

In chapter 4 we proposed a research agenda focussing on two particular aspects of informal payments that are key to establishing the health policy relevance of this phenomenon: the scale of informal payments and the motivation of participants. Taking the 'donation' explanation we formulated research questions and tested corresponding hypotheses with the available empirical evidence. We concluded that it is not possible to reach a conclusion on the basis of existing evidence, so justifying further research in this area. Consequently this chapter takes the research agenda set out in chapter 4 as the starting point for the empirical part of our study.

First, the research questions and hypotheses are selected. Then the chapter describes the issues, which informed the choice of research methods, including broader methodological considerations and experiences in relation to informal payments. Finally, each of the research methods employed in this study is explained in detail.

5.1. Objectives, research questions and hypotheses

The main objective of the study is to establish the importance of informal payment for health policy in Hungary. As we have argued before, this has two aspects. First, we must establish the magnitude and distribution of informal payments to demonstrate that any possible adverse effect of the phenomenon on the performance of the health care system is not negligible. Second, we need to clarify the controversies concerning participants' motivation, so as to determine whether informal payment does have the potential to affect system performance adversely.

We have identified participants' motivation as being of crucial importance in this respect, given the contrasting claims and implications of the 'fee-for-service' and the 'donation' explanation of informal payments. Consequently, in order to establish the policy importance of informal payments we must refute gratitude as the most prevalent motive among patients. We focus on the validity of the gratitude payment concept, which allows us to apply a wider range of empirical evidence to the issue. Thus, going beyond examination of the stated motivation and the context of utilisation, the objective of the study is to address the impact of informal payments on equity according to the assumptions derived from the 'donation' explanation, as discussed in the previous chapter.

Table 5.1. Research questions and objectives of the study

Main objectives, research areas and research questions	Hypotheses (‘Donation’ explanation)
To establish the magnitude and distribution of informal payments	
Q1. What is the overall amount of informal payment in a year?	Scale is indifferent
Q2. How is it distributed among health workers, especially physicians?	
To establish the impact on equity of informal payments	
Q3. Does it influence access to care?	No
Q4. Does it influence the distribution of cost burden of care?	Yes, but payment is the function of ability to pay
To establish the main motivation of participants	
Q5. What is the principal motivation of the actors?	Gratitude
Q6. Does the stated motivation fit in the circumstances of payment?	Yes

It has not, however, been possible to include the whole research agenda set out in chapter 4 in the empirical part of our study. It was necessary to reduce the original, more comprehensive plan twice during the conduct of this study to arrive at a realistic agenda, presented in Table 5.1. This is a shortened version of Table 4.1 from which the origins and causes, private sector informal payments, as well as the determinants of informal payments have been excluded because of the scale of the undertaking that would have been required.³⁷

5.2. Research strategy

This section justifies the methods that I have selected to address the research questions in Table 5.1. I have taken account of methodological issues, including my ontological and epistemological position, previous experiences with research methods addressing the informal economy in general and more specifically informal payments for health care, ethical and political issues, feasibility (or as Mason [239] put it practical matters), as well as the strategy for analysis. The aim of the research and its background were discussed in the introductory chapters to this thesis. All of these issues informed the choice of methods and the study design [240; 239], but by no means in a sequential manner, and not only in the planning phase. Ideally the appropriateness of the method to address a research question should be the most important criterion for these choices, and I agree with Mason [239,p.25] that researchers should begin with “*the fullest and most creative range of data generation and data sources*”. I would argue, however,

³⁷ Originally, I planned 43 research questions in 6 main research areas, which were reduced to 4 main research areas with 17, and later on 6 research questions. I consider this process a very important lesson to learn. The realistic assessment of feasibility is of key importance for the successful implementation of any research project, but especially within the frame of PhD studies, where one of the critical success (→)

that creativity is equally important, when constraints of feasibility, for instance changes in funding, deny us the most appropriate option. The next section will thus synthesize the considerations discussed here to arrive at the final choice of method for each research question.

5.2.1. METHODOLOGY

According to Mason [239,p.30] the choice of research method should be guided by an overall methodological strategy, essentially the *“logic by which you go about answering your research questions”*. This methodological strategy translates the researcher’s more general assumptions (beliefs) about the nature of social reality (ontology) and the nature of knowledge and evidence (epistemology) into actual research methods, but the ontological and epistemological position is more pervasive insofar as it lies behind the selection of research topic and the strategy for analysis [239,p.14-16,37-38,173-204]. From the methodological point of view the importance of varying ontological and epistemological standpoints is that they suggest different research methods to use, which can be incompatible if the standpoints, which they stem from contradict each other, or as Lincoln and Guba [241] put it, are incommensurable [e.g.241; 242; 239]. Hence, there are various sets of basic beliefs regarding ontology, epistemology, methodology and axiology, known as scientific paradigms [243,p.157; 241] or models [242,p.77], and more loosely formulated epistemological stances, known as perspectives [243,p.157] with specific preferences for and interpretation of methods. Research methods thus are not *“mere techniques”*, but *“techniques which take on specific meanings according to the methodology in which they are used”* [242,p.89], and this poses a considerable challenge where multiple methods are used, especially if qualitative and quantitative methods are mixed [242,p.98-99; 239,p.33-36,59-60].

I cannot pretend that when I started to work on this research topic I thought about research methods as strategically as Mason [239] urged us to do, insofar as I did not explicitly formulate either the ontology or the epistemology I subscribed to. Drawing largely on Babbie’s [84], otherwise excellent and easily accessible work, I was unaware that I actually followed what Lincoln and Guba [241] called a post-positivist paradigm, in which quantitative as well as qualitative methods could be considered along the conventional positivist criteria of validity and reliability. Having made the decision more conscious by reflecting on these issues in connection with the study design described below, I consider my position to be one that in some respects integrates the

factors is to finish the work in time. I am especially grateful to my supervisor for not letting me fall into (→)

critique of positivist beliefs. I use Lincoln and Guba's [241] conceptual framework, which distinguishes five main paradigms (positivist, post-positivist, critical theory et al, constructivism, participatory), and description to illustrate my points [241,pp.168,170-173].

According to Lincoln and Guba [241] the ontology of both the positivist and post-positivist paradigm is characterised by realism, the belief that social reality exists independent of our minds ("*'real' reality*"), and consequently there are facts and laws "*out there*", which can be established if the researcher's personality does not interfere with the process of knowing (disengagement, objectivity) [see also 240,pp.9-11], a key issue discernible in the positivist criterion of reliability. Acknowledging the relevance of the critique by the followers of other paradigms and perspectives, I contend that critical theory, constructivism, or perspectives such as feminism and philosophical hermeneutics would invalidate the positivist/post-positivist scientific framework. I would rather say that the rightful criticism by, for instance, critical theory and feminist researchers about value-free science, disengagement and rationality [see 240,p.17-26; 241], or the constructivists' rejection of the context free being, the "*'real' reality*" [241; 244], draw attention to how the positivist paradigm is built on implicit assumptions about shared understanding, whose ignorance could preclude research relying on positivism/post-positivism producing valid knowledge. I argue, however, that the problem of shared understanding is more pervasive and cannot simply be resolved by integrating the critique of independent social reality into the positivist framework through the replacement of objectivity with the notion of inter-subjectivity [84,pp.77,87], i.e. a negotiated reality. First, I share the views of, what Schwandt [244,p.177] called "*an ordinary sense of constructionism*" or perspectivism, which says that knowledge about social reality is not discovered, but constructed, insofar as people "*invent concepts, models, and schemes to make sense of experience*", and that this process is not isolated from the historical and socio-cultural context in which it takes place. That is, social reality is not just negotiated, but constructed within a particular context, which suggests that it is false to assume unity of these created concepts among groups of people or even individuals. Second, if this is the case, feminists may rightly criticise the positivist researcher ideal, insofar as disengagement, for instance a lack of empathy or identification with the research subject, prevents understanding of these differences. Consequently, I argue that the positivist/post-positivist framework can work well if there is a shared understanding and agreement of the constructed and

the trap of overambitious scope, where my enthusiasm and inexperience would have led me.

negotiated social reality, but if this underlying condition does not apply, research based on the positivist paradigm is unlikely to be able to establish it. In this respect maybe it is not an exaggeration to compare the revolution that qualitative inquiry has brought to the theory and practice of social sciences to Einstein's theory of relativity in physics, with the positivist view of social reality analogous with Newtonian mechanics, insofar as both are a derivative of a more widely applicable general framework.

I consider research on informal payments in Hungary, particularly on the motivation of participants, a good example of the point that, if shared understanding is taken for granted but in fact is not there, positivist research cannot produce conclusive evidence. One of the crucial themes of this study is to examine this problem by exploring the context of giving and contrast it with the personal motives revealed. On the basis of the contradictory evidence I hypothesise that motivation is a complex issue that cannot be easily understood, and in particular cannot be captured as a one-dimensional category in a context characterised by ambiguous policies, equivocal legal frameworks and outright dishonesty. Consequently the very condition of shared understanding must have been (is) absent, which suggests that research based exclusively on a positivist epistemology is insufficient to address the issue of motivation.

Nonetheless, I do not wholly agree with the anti-positivist criticism, especially when it takes relativism to its extreme. I argue that the uncritical infiltration of the research process with values, the 'victory' of the unjustly oppressed emotion over rationality, and over-emphasised individuality of experience and knowledge (i.e. the 'idiosyncratic' nature of social reality) in fact erodes, or even eliminates the very foundation of science itself. Among the epistemological stances for qualitative inquiry, "*strong holists*" argue that there is no rational basis (foundational criteria) to distinguish between more or less correct interpretations, with the implication that justification is irrelevant as "*there are many equally acceptable interpretations*", or that justification is solely based on "*rhetorical criteria – whether an interpretation invites, persuades, compels, entertains, evokes or delights*" [244, pp.201-202 my emphasis]. The question then obviously arises: 'is there any difference between scientific and everyday knowing or knowledge, and between a scientist and an artist?' Taken to its extreme, this position may endorse an interpretation full of what Babbie [84] calls common errors of everyday knowing, for instance inaccurate observation, over-generalisation, selective perception and bias, just because the researcher possesses the skills to present it amusingly. If not then there must be some criteria after all – maybe not foundational in a sense that they exist 'out there', but that they are negotiated and agreed upon, hence independent from

individual researchers – to discriminate between better and worse knowledge other than the elocutionary talents of researchers. These are different from conventional positivist criteria but exist as a modified version of validity [e.g. “extended consideration of validity” in 241,p.173,178-182; and “weak or nonsceptical holism” in 244,p.202].

I argue that knowledge assessed against these criteria could gain increased legitimacy of being scientific, but there are limits to what science can claim to know about social reality. Feminist perspectives may rightly criticise the axiology of positivism, when they argue that the concept of value-free science is untenable [e.g.240,p.54-59], but I contend that the infiltration of all stages of the research process with values would invalidate the means and ends distinction of Mill and Weber [quoted in 240,p.56-58; 245,pp.135-138], i.e. *“it is logically impossible for the social sciences to establish in a scientific manner the truth of ideals which people believe in”* [240,p.55]. For me this does not mean that researchers cannot analyse or even criticise ‘ends’, but that they cannot claim the legitimacy of science to back up their value position and impose it on others. This was one of the most important reasons why I selected the policy framework of Roberts et al. [53] as the framework of the current study.

Relating the importance of informal payments to the health policy objectives (ends) of Hungarian governments I have not just followed the means and ends distinction to separate ‘value claims’ from ‘scientific claims’, but surpassed the positivist axiology, which, according to Lincoln and Guba [241,p.172], regards knowledge as intrinsically valuable.³⁸ Rejecting the intrinsic value of knowledge, however, does not mean that I subscribe to the axiology of critical theory, constructivism or the participatory paradigm. It is not primarily because the proposed ends, such as *“flourishing in a culture”* are not self-evident, but because I dispute that a society pursues only one end, or where there are multiple ends, prioritise them in a fixed manner. I would argue that there could be many values, equally appealing to different members of society, and goal setting involves only temporary fixing of priorities in a way that creates an appropriate balance between these values over a long period of time.

³⁸ Nonetheless I would argue that this characterisation is perhaps too simplistic. If knowledge was indeed intrinsically valuable, then there would be no constraints on what researchers can do to generate knowledge. In contrast, conventional research ethics, which aims to protect research subjects, does impose restrictions on the research process, which suggests that for instance the individuals’ right to refuse to be studied is more valuable than the knowledge could have been gained by neglecting informed consent.

5.2.2. METHODS IN THE STUDY OF INFORMAL ECONOMY

In this section we review experience of using different methodologies to research the informal economy, so setting the broader context for methods to study informal payments for health care. Some studies in Hungary addressed informal payments as part of the “*hidden economy*” as “*invisible incomes*” [232; 200; 223; 225], but we can also draw on the work of Harding and Jenkins [230,pp.54-102], who present a detailed review of research studies and methods from a critical perspective.

Fuelled by the interest of politicians, much of the research in this area has been concerned with measuring the scale of the informal economy, either indirectly by using, what Thomas called the “*statistical fingerprints*” of the black economy [quoted in 230,p.55], or directly by asking consumers or providers of informal economic activities [230,p.54-55; 223,pp.103-118], but direct approaches were also employed to explore the phenomenon in specific settings, such as the workplace or the household [230,p.83].

In her methodological review, Ékes [223,pp.103-118] sets out five different indirect methods for the measurement of the informal economy, all of which are based on the analysis of official statistics, including money supply, labour market, household expenditures, national accounts, and taxation, which, by and large, correspond with Harding and Jenkins’ list [230,p.55]. They discuss another interesting indirect method, Smithies’ approach [246; cited in 230,pp.74-76], which took local newspaper reports of court cases, examined over time, to draw conclusions about the size of and change in the black economy. As pointed out by Harding and Jenkins [230,pp.75-76], the weakness of this and other indirect methods lies in the questionable validity of assumptions concerning the association between the true informal economy and the actual measures used, i.e. the problem is not primarily methodological, rather conceptual [see also 223,pp.103-117]. Even if we assume that official statistics provide good quality data, which is not at all self-evident, we must demonstrate that the available data do have the ‘fingerprint’ of the informal economy on them, and changes are attributable only to changes in the informal economy. For instance, estimations using cash flow assume that transactions in the informal economy mostly involve cash so that increased demand for cash is an indicator of the expansion of the informal economy. This monetary approach involves other assumptions, such as that the formal economy is based on non-cash money transfers and that its expansion increases only non-cash money transfers, none of which is supported by much evidence [223,pp.107-110]. The weakness of these approaches is clearly demonstrated from empirical evidence on informal payments, such as that by Ádám [49] who compared reports of

proceedings in the official journal of the Ministry of Health, and found a steady decline between 1959 and 1984, at a time when surveys indicated the opposite trend.

Harding and Jenkins [230,pp.83-101] discuss surveys, participant observation, and the time-budget (diary) approach (used to document daily activities) as direct methods used in the study of informal economic activities. They consider the wording of questions, respondents' reaction to these types of questions and respondent bias as the most important challenges facing survey research, however only the last of these is addressed in more detail [230,pp.86-93]. The respondents' fear of detection can lead to underestimation (as most informal payment researchers have argued in Hungary), but overestimation is also possible as a result of "*the bravado of informants*" [230,pp.88] seeking status enhancement (as Balázs [231] has suggested this possibility in connection with informal payments for health care). Harding and Jenkins [230,pp.88] cite the research of Edgell and Hart [247] on informal economic activity among fire-fighters, where both phenomena have been observed. Concerning respondent bias, Pahl and Wallace [248; quoted in 230,pp.86-87] complemented their household survey of paid informal work with in-depth, follow up interviews on carefully selected sub-samples (using different researchers), and informal (participant) observation in the area. These not only confirmed the survey findings but added to their interpretation.

In conclusion Harding and Jenkins [230,pp.101-102] argue that there is no one best method for research on informal activities, as both direct and indirect methods have their shortcomings. However direct approaches may be more defensible (especially if they are used in combination with each other). This view is shared by Ékes [223,p.191], insofar as she considers expenditure surveys as the best method to measure the informal economy in Hungary. Furthermore, Harding and Jenkins [230,pp.83,100-102] argue that the various direct methods are best suited to different settings and different types of informal economic activities; for instance time-budget analysis to the study of the household and participant observation to certain work-place related activities, such as fiddling, but not self-provision or moonlighting. On the other hand they argue that the illegality of many such activities creates difficult ethical and political dilemmas, which we will return to later in this chapter.

The study of informal payment for health care has specific features in terms of the setting and participants, and it is different from the general topic of informal economic activities inasmuch as understanding the nature of the phenomenon is at least as important as the magnitude and distribution of payments, which studies of the informal

economy mostly focus on. Consequently it requires consideration of a wider selection of research methods.

5.2.3. METHODS IN THE STUDY OF INFORMAL PAYMENT

As we have discussed in chapter 4, informal payments in the Hungarian health care system so far have almost exclusively been addressed in surveys, usually as a secondary issue, and according to the review by Lewis [96,pp.11-16] this dominance by surveys is characteristic for other countries of the region, not just for Hungary. The few exceptions are mostly qualitative interviews of individuals (in-depth or semi-structured) and groups (focus groups), including patients, physicians and administrators [96,pp.12-16; 104; 83; 199; 71; 216], while there is also a content (Vágó, unpublished) and a historical analysis [49]. Unfortunately few methodological considerations are discussed in these publications, and these are usually not related to the suitability of different methods. Nevertheless, some findings are relevant to the selection of research methods, even if these are not discussed in the original papers.

Next, we will consider the suitability of a wider range of techniques for addressing the main research areas outlined in Table 5.1, along with the methodological experiences distilled from the studies on informal payment conducted so far.

5.2.3.1. Methods in measuring the scale of informal payments

One objective of this study is to establish the importance of informal payment in terms of its scale, which obviously requires some sort of quantification. The demonstration that informal payments are large enough to influence the behaviour of providers, however, does not require absolute precision, but should just resolve the contradictions of an order of magnitude between figures obtained in the literature review. Hence we have considered only a limited set of options, including official statistics and surveys, and setting aside the detailed discussion of all the methodological subtleties the measurement of informal phenomena would otherwise involve.

Official statistics of the kind discussed by Harding and Jenkins [230] and Ékes [223] mostly contain aggregate numbers that do not allow separate identification of informal payments, with the possible exception of those household expenditure statistics where informal payment for health care is captured separately. Data collection, however, is usually not tailored to this particular research question, hence it is not possible to analyse the issue in depth, for example to assess the distribution of informal payments according to levels of care or type of services. Data accuracy could also be problematic and the way official statistics have been constructed requires thorough consideration

[e.g.84,pp.356-364; 240,pp.71-87]. We have identified two sources of official statistics in Hungary that could be relevant here: the Tax Office and the Hungarian Central Statistical Office (HCSO).

The Tax Office has been gathering information on informal payments since 1989 when the government decided to try to tax the so-called ‘invisible incomes’ of health workers. If the income tax return contains a separate question on ‘gratitude payment’, that would, in principle, allow assessment of the magnitude and distribution of informal payments from the recipients’ perspective. However the validity, reliability and accessibility of these data are questionable. Data accuracy ultimately depends on physicians’ willingness to admit income from informal payments, but despite the intentions documented by Ádám [8], I am not aware of any effort to enforce such declarations. Threats by the Tax Office, on the other hand, could induce some physicians to declare an income from ‘gratitude payment’ even if there was none in order to reduce the risk of harassment. Moreover, taxation data may not be accessible for research purposes if a particular, well defined population is the focus.

There is a regular income-expenditure survey of households conducted by the HCSO, which contains a section about health expenditure in which, ‘gratitude payment’ and expenses for health services are identified separately. The obvious advantage of this data source is its ready availability, allowing the assessment of trends according to a standardised methodology, even if the aggregate figures limit analysis in depth. The HCSO has used the time-budget approach to estimate household income and expenditures. This method, in principle, enables a detailed and accurate recording of both, but keeping a diary is a demanding task, which raises the possibility of inaccurate recording and, as we have discussed in chapter 3 and Appendix F, the concept of ‘gratitude payment’ is also in question. Thus the study design has to be explored critically to assess its impact on the accuracy of data.

As it has been pointed out by Harding and Jenkins [230] direct quantitative methods constitute more defensible approaches to the assessment of the magnitude and distribution of informal economic activities than the use of official statistics, and this, I contend, also applies to informal payments for health care [see also 223]. Such direct methods increase the likelihood of getting information from those involved in the activity, whether individuals or households, but unlike the analysis of official statistics, direct methods allow the researcher to decide on the source of data and the technique of data gathering, making it possible to carry out more detailed analyses focused on the study objectives, and potentially increasing the validity and reliability of the data by

minimising selection, respondent and recall bias. As we have discussed in chapter 4, all have been identified in the study of informal payments in Hungary.

For instance, prospective methods, such as cohort studies or time-budget analyses have the potential to minimise recall bias compared to surveys. Conversely, surveys are relatively easy to administer, they enhance the probability of external validity, and minimise the demands on respondents, compared, for example, with diary keeping that may increase the risk of refusal and possible resultant selection bias. Furthermore, surveys have the additional benefit that many topics can be studied in parallel.

Potential data sources include individuals and households, whether among the general population, patients or physicians, but the method used to access these informants has implications for data reliability and validity. In chapter 4 we have discussed the influence of the setting (during hospital stay or after treatment is completed or at home after discharge) on responses, but there is evidence from Poland, where an exit survey met “*virtual silence*”, that selection of an appropriate setting is a critical success factor [96,p.15]. Lewis suggests an alternative, to identify patients from “*insurance rolls*”, but access to such data is prohibited in Hungary [249], which makes access to patients very difficult other than via a general population sample.

In principle, the scale of informal payments can be addressed from either the givers’ or the recipients’ side. Experiences with the latter, however, have shown that it is unrealistic to expect physicians to provide accurate information on their income. Polonyi [229], who has enquired about the overall income (including ‘gratitude payment’) of a nationally representative sample of medical doctors, has found that the average declared income in the ‘non-paying’ specialities was somewhat higher than in the ‘paying’ ones. Using in-depth interviews Szabó [83] found a reluctance among physicians to discuss actual amounts of informal payments, although after several attempts she was able to elicit some information. Nonetheless, the finding that people are usually more willing to talk about their expenditures than their incomes corresponds with the experiences of similar surveys [200; 223; 75]. This is especially relevant in the specific situation of physicians in Hungary, who face double jeopardy if detected: the potential consequences of the ambiguous legality of informal payment, and of tax evasion. There is, of course, the possibility of eliciting information from physicians indirectly, thereby masking the true intentions of research and making the question less sensitive. The conceptual problem with these ‘tricky’ methods lies in the validity of the indirect measure employed. For instance the TÁRKI-1992 and 1996 studies asked physicians about their expectations in terms of income [229; 216], but it is not apparent

that this will necessarily equate to what they do earn (formally and informally). Such methods have also been attempted with patients (e.g. in the SOTE-1995 study of the willingness to replace informal payments), but direct questioning of patients has been considered much less problematic in terms of respondent bias [e.g.223; 96,p.10].

In conclusion, the most suitable method for addressing the scale of informal payments seems to be gathering information on expenditure directly from individuals or households. Whether to use questionnaires or dairies is not clear cut, as the possible distortion arising from recall bias has to be balanced against the increased chance of selection bias. Nevertheless for the purpose of our study the analysis of official statistics seems to be sufficient, since obtaining the most precise estimate is not the objective of our study, and the main data source, the regular household budget survey (HBS) of the HCSO employs the time-budget (diary) method anyway. Secondary analysis of previous surveys, which we have identified in chapter 4, have not, however, been ruled out, insofar as they can enrich the available body of evidence at little extra cost, but the same cautions apply as in the case of official statistics.

5.2.3.2. Impact on equity

One of the major problems with surveys and other cross-sectional study designs, however, that it is rarely possible to identify the causation of observed associations [e.g.84,pp.121-123], which is an important aspect of the impact of informal payments on system performance or the effectiveness of different policy options. Longitudinal (observational or experimental/intervention) studies can establish temporal relationships, while certain intervention studies, such as randomized controlled trials, are designed to control for confounding factors [e.g.84,pp.251-275,373-399]. Nonetheless, such methods are not always necessary, for instance if the temporal relationships between variables are unequivocal, or if we can ask survey respondents to establish the sequence of events [84,pp.123-125].

In the case of equity of financing the temporal relationships are clear-cut, while in the case of access to care they are irrelevant. As we have discussed in chapter 3 and Appendix F, the interpretation of before and after in health care is problematic, hence it is immaterial when exactly the money was paid. Any difference between ‘paying’ and ‘non-paying’ patients implies unequal access to care.

5.2.3.3. Understanding motivation

The central theme of our study is to understand the motivation of patients with a focus on gratitude. Lewis argues [96,p.15] that “*surveys are clumsy tools for capturing the*

perceptions and beliefs that underpin the practices of informal payments”, and indeed, as the review of the literature has shown in chapter 4, in Hungary surveys have yielded contradictory findings that cannot be explained only by methodological differences. We argue, however, that qualitative methods cannot only make sense of quantitative findings, as suggested by Lewis [96,p.15], or to generate ideas and hypotheses, as stated by Babbie [84,p.304], but can also cast light on the limitations of survey methods in measuring complex or ambiguous concepts.

Our research has sought to identify patients who claimed that they gave because they were grateful and to explore the broader context in which informal payment occurred. The obvious choice is in-depth interviews, which Pahl and Wallace [248; quoted in 230,pp.86-87] employed to complement their survey of households on paid informal work, and which provided important insights into how informal payment actually worked in real life in the MTA-SZKI-1983 [199] and the SZEKI-1983-84 studies, albeit in the latter from the perspective of physicians [83].

Group interview techniques, such as focus groups can enhance the information that can be obtained from individual interviews through the interaction of group members, and are best suited for issues shaped by group norms and real life dynamics [e.g.240,pp.125-126]. Although in other countries focus groups have been used in the study of informal payments [96,p.16] the methodological rationale and experiences have not been discussed, and there are some findings from Hungary which suggest that the application of focus groups might be limited. In the SZEKI-1983-84 study Szabó [83] found that informal payment is a taboo subject between medical doctors, which suggests that a great deal of the phenomenon occurs in private (i.e. between patient and physician only). This also creates considerable difficulties for the use of participant observation, along with the previously discussed influence of the setting on the honesty of elicited opinions and the inevitable ethical dilemmas entailed by covert participant observation [230,pp.96-101].

In summary, a survey coupled with in-depth follow-up interviews seems to be the best approach to address the issue of gratitude as a motive for informal payments. Although the most complete approach would be to identify and interview the physicians with whom the surveyed patients interacted, this is not possible without breaching the anonymity of patients. Nonetheless, the perspectives of physicians are important for understanding the motivation for paying for health care informally, even if they can contribute only to the wider picture.

Finally, it must be noted that quantitative methods alone could contribute to understanding the role of gratitude in giving, insofar as a survey addresses both the motivation of informal payment and measurable aspects of the context of giving, for instance patient satisfaction, the timing of payment, and so on. If appropriate data from previous studies are available, secondary analysis can yield valuable insight into the issue without considerable extra effort.

5.2.4. ANALYTICAL STRATEGY

In the previous sections we have considered the appropriateness of various research methods to address the research questions outlined in Table 5.1. The methodological issues discussed earlier suggest that answering all questions require multiple methods, which combine qualitative and quantitative approaches. However, as argued by Silverman [242] and Mason [239], multiple mixed methods, using different units of observation and analysis, and producing different types of empirical findings, create the challenge of how to integrate them during data analysis, especially if the methods draw on different ontological and epistemological perspectives.

There are two reasons why I do not see the analytical integration as problematic. First, as I have argued in the section on methodology, the positivist/post-positivist paradigm is not totally inconsistent with the key tenets of interpretivist paradigms. Second, the research does not seek methodological triangulation in sense that same topic is addressed with different methods, but rather it uses multiple methods to address different topics, albeit each connected to one another at the level of theory, as described in chapter 3. The only exception, though, is the stated motivation of patients, but here we do not need to corroborate the findings of different methods, but rather to demonstrate the inadequacy of surveys in capturing the true intentions of respondents. Consequently, the purpose of multiple mixed methods in this study is to shed light on different parts of the same picture, and on the same picture from different angles.

This strategy is very well illustrated with the metaphor of Mason [239,pp.17-18], who talks about research as an intellectual puzzle, which is in our case is a jigsaw, and with the metaphor of Denzin and Lincoln [239,p.4-6], who see the researcher as “*bricoleur*” or “*quilt maker*”, in our case producing the ‘quilt of informal payments for health care’.

5.2.5. FEASIBILITY (PRACTICALITIES)

According to Mason [239,pp.43-44] the choice of methods is inevitably constrained by practical matters, such as available financial resources, time and skills, but she argues

that feasibility should be accommodated within the intellectual framework and not vice versa. Practical problems do not emerge only in the planning phase, but also during the conduct of research, and consequently require adaptation that will not undermine the intellectual soundness of the study [239,pp.44]. Of course our study was no exception, but fortunately practical constraints did not upset the foundations of the underlying intellectual framework.

The three (maximum four) year time frame of PhD studies with one year for data collection has limited the number of research questions and methods, which could be addressed realistically, while the available financial resources placed further constraints on the choice of research methods. Initially the 'Health Services and Management' project of the Ministry of Health financed my studies, and there was enough money for fieldwork to implement for instance a large nationally representative survey. However, the project came to an early end, which removed virtually all the money for research, and made the anticipated costs a critical factor. Fortunately we managed to find sponsorship in the frame of an international collaboration, which allowed us to return to the original plans with some modifications.

Other practical obstacles have limited access to data sources. For instance health care provider institutions and the NHIFA have excellent sampling frames for patients, but these are not accessible for research purposes in Hungary because of the confidentiality of medical records [249]. As we have mentioned before the alternative is to recruit patients at surgeries or immediately after discharge (exit surveys), but experiences with this technique are not encouraging in terms of willingness to participate [96,p.15; 226].

Of course there have been other practical problems in the course of the research, which are related to the methods that have been finally selected, but these are discussed in the sections describing the detailed study design.

5.2.6. ETHICAL AND POLITICAL CONSIDERATIONS

All research can raise ethical and political dilemmas [e.g.84,pp.526-546; 240,pp.59-67; 245], which must be considered in the choice of research methods [239,pp.41-43]. This is especially so with a research focused on an activity that is illegal or clandestine [230,pp.97-101], but the ethical issues are certainly more prominent for some methods than others. Participant observation, for instance, would certainly raise the problem of whether to reveal the identity of the researcher, as remaining covert would increase the information that could be collected. Nonetheless our choice of methods and the conduct

of the research have been guided by the standard ethical principles of informed consent, the rejection of deception and the protection of privacy and confidentiality (i.e. preserving anonymity) [245,pp.138-140], with the realisation that it is not always possible to adhere strictly to these rules (for instance to preserve the anonymity of research locations, for example where there is only one appropriate site, e.g. one private for-profit hospital in the whole country).

Furthermore, as Harding and Jenkins [230] have pointed out, the publication of research results could have a negative effect on those studied, even if full anonymity is preserved, given the illegal nature of most informal economic activities. They argue that research on informal economic activity is by its nature political, and while it is not possible to control the use of the published data, the researcher at least should consider the possible harm which the publication might cause to those who have been studied. This is certainly an important point for informal economic activities in general, but we argue that topic of informal payments for health care in Hungary is different in this respect. As we have discussed in chapter 2, the history of informal payments has always been characterised by an ambiguous legal status and ambiguous policies; for instance it should still be declared in income tax returns. Further, there is evidence that informal payments are widespread in Hungary (chapter 4), which makes its contested legality/illegality immaterial. Finally, the TK-1985 study has shown that the majority of people disagree with the practice of informal payment [79], which makes any research on the topic a laudable effort, as it holds the possibility that ultimately most people in society will benefit.

5.3. Research questions and methods chosen

In the section we will synthesise the arguments concerning the issues that have informed the choice of research methods and in turn the final study design. For each of the major research areas we have selected one major research method and corresponding data sources and data collection (generation) techniques,³⁹ but the selection process has been interactive, insofar as the choice of one method has informed

³⁹ Reading a number of books on research methods and methodology [84; 243; 242; 240; 239] I have had the impression that there is no consensus on what exactly is a research method as opposed to techniques, approaches, or even studies, which have sometimes been used in a very similar sense. To resolve this problem, I have found very useful Silverman's [242,p.89] distinction of methods and techniques, and Mason's [239] distinction of data sources and methods. If we define method, which encompass the whole data generation process from the identification and selection of sources, through techniques of gathering data to data analysis, and whose final product is evidence, we can say that methods are often, but not always, named after the technique of data collection (inquiry). For instance the case study method emphasises the selection of the object to be studied, and not the inquiry technique [250,p.236].

the choice of another method and vice versa. As we shall see, however, this does not mean that one main research area has only been addressed by one method. We have, of course, utilised the potential of other methods to complement the data generated by the main method concerned.

The backbone of the research has been made up of methods that we have selected to address the motivation of patients directly. Drawing on the inconclusiveness of available evidence we hypothesise that surveys cannot capture the complexity of the motivation issue because of the lack of shared understanding, thus they cannot discriminate between payments that are given truly voluntarily and those that are coerced, in its wider sense (chapter 3 and Appendix F). To capture the 'coercion factor' in informal payments, we must explore the context of giving and contrast it with the stated motivation revealed by patients in surveys. More specifically, we need to identify patients who have reported paying out of gratitude, and explore the context in which it actually happened. As we have argued before, in-depth interviews are best suited for this task, because of the covert nature of informal payments and the individual nature of the experience, but also because much depends on the perception and previous experiences of patients, which cannot anyway be observed. Furthermore, in-depth interviews less likely to involve serious ethical dilemmas than participant observation.

Initially we planned a national representative survey, but as we have pointed out before, this had to be dropped, chiefly because of financial reasons. Fortunately, later we obtained sponsorship that would enable participation in a household survey, although not national level, but adequate for the task of identifying cases for the in-depth interviews. A patient sample may have been better, but the key issues of study design have been determined by the international project team, and, as we have pointed out previously, direct access to patient sampling frames is complicated in Hungary. Furthermore, the survey itself, especially when combined with secondary analysis of previous surveys, could make it possible to go beyond the stated motivation, insofar as they addressed questions related to the context of giving.

For the exploration of the context of giving, we have considered as equally important the perspectives of physicians. The best option would have been to identify those physicians, who participated in exactly those transactions that we have identified from the household surveys, but this would have revealed the identity of patients, hence we have dropped the idea for ethical reasons. Instead, we have identified a general sample of physicians working in the health care facilities of the town where the household survey was carried out.

Given that the survey was not nationally representative, we have not considered it appropriate to use it as a primary source of evidence to answer the research questions on the magnitude and distribution of informal payments. Here, we have opted for the analysis of the regular HBS of the HCSO. This has the advantage of cost-effectiveness and provides direct data on expenditure (time-budget or diary approach), which, despite its shortcomings, researchers have considered one of the best methods of measuring informal payments [223,p.191]. As already noted, it is only necessary for the present purposes to determine the order of magnitude of informal payments and not their precise amount.

In contrast, as the topic being virtually unexplored, we have used our survey as the primary method to explore the impact of informal payments on equity.

An equally important part of our research strategy was that we explored and utilised the potential of the aforementioned primary methods for addressing questions other than the one for which they have been chosen in the first place. For instance, we have found relevant data in the household expenditure statistics of the HCSO to address equity in financing, and we have used secondary analysis to generate complementary evidence for all main research topics.

In summary, Table 5.2 presents the final choice of research methods, according to the main research topics (questions) of Table 5.1. These methods have formed the basis of the study design, which the next sections describe in details.

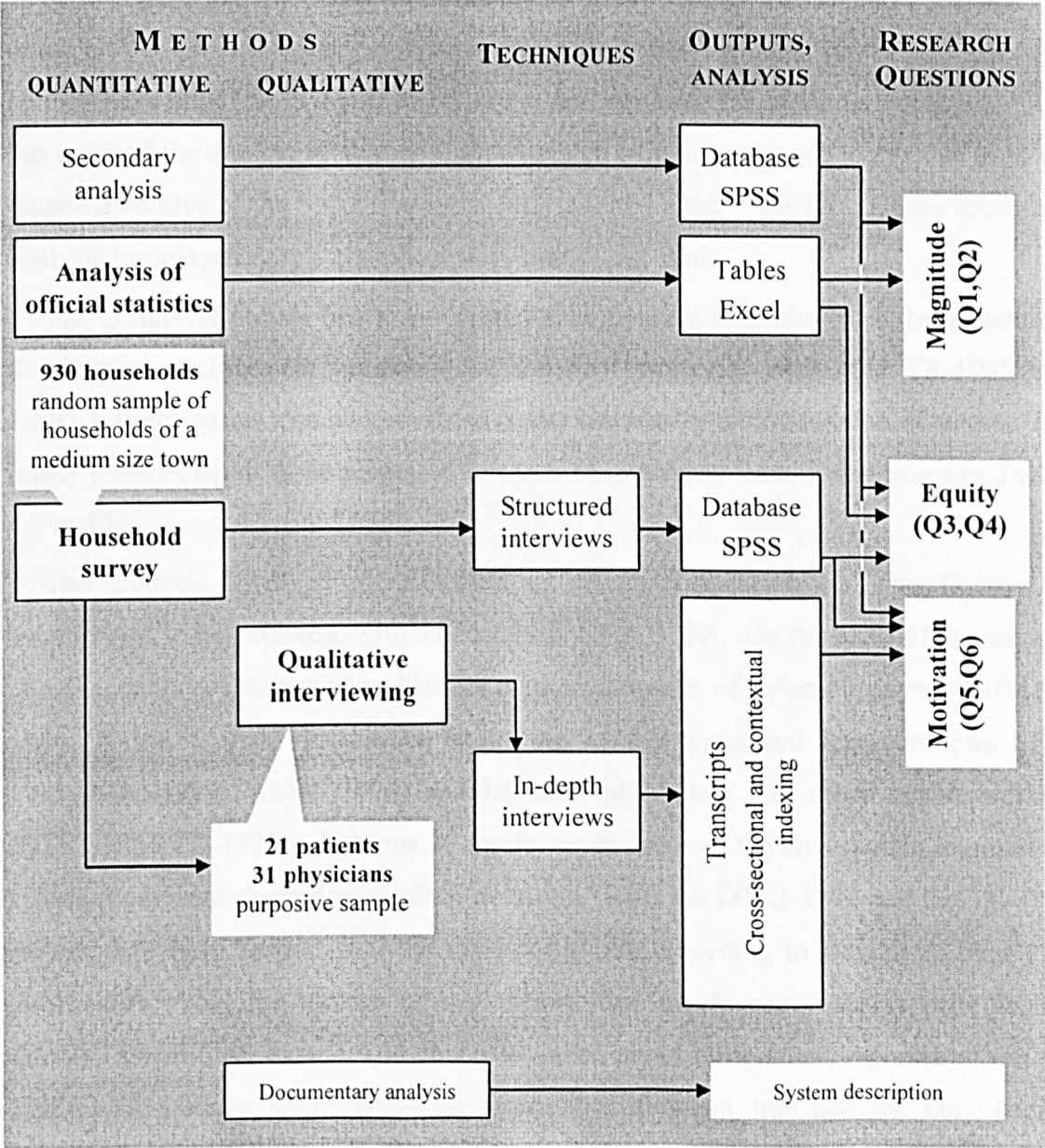
Table 5.2. Research questions and methods

Research Areas / Questions	Primary Method	Sources of Data	Technique of Data Generation	Justification	(Possible) Drawbacks	Complementary Methods
Magnitude & distribution						
Q1, Q2	Analysis of official statistics	Hungarian Central Statistical Office (household survey, diary approach)		<ul style="list-style-type: none"> • Low costs • Appropriate technique • No special accuracy is needed 	<ul style="list-style-type: none"> • Data quality? (selection, recall and respondent bias) 	<ul style="list-style-type: none"> • Literature review • Secondary analysis • Survey
Equity impact						
Q3, Q4	Survey	Households	Structured interview (questionnaire)	<ul style="list-style-type: none"> • Low costs (economies of scope) • Feasibility (time constraints) • No longitudinal design is needed 	<ul style="list-style-type: none"> • Generalisability • Limited potential to address equity in delivery 	<ul style="list-style-type: none"> • Analysis of official statistics • Secondary analysis
Motivation						
Q5	Qualitative interviewing	Patients, physicians	In-depth interviews	<ul style="list-style-type: none"> • Perception and experiences matter • Ethically least problematic 	<ul style="list-style-type: none"> • Generalisability 	
Q6	Survey	Households	Structured interview (questionnaire)	<ul style="list-style-type: none"> • Low costs 	<ul style="list-style-type: none"> • Selection and recall bias 	<ul style="list-style-type: none"> • Secondary analysis

5.4 Study design

This section provides a more detailed description of how the data have been collected and analysed using the methods chosen. The overall study design is shown in Figure 5.1. We describe each method according to the following criteria: objectives, unit of analysis and observation, study population, sampling method, sample size, data collection, data processing and analysis. We also consider the limitations of the methods in addition to the general pros and cons discussed before.

Figure 5.1 The design of the study



5.4.1. SECONDARY ANALYSIS

In the literature review in chapter 4, we pointed out that important elements of many previous studies have remained unanalysed and unpublished. Hence we began the research by looking at these sources and undertaking new analyses of the data that would address the study questions, going well beyond the simple tabulations that had been reported in the original publications.

We created a shortlist of studies on the basis of, first, their potential to address the research questions and second, the quality of research. Some previous empirical studies were poorly designed and implemented, so we dropped, for instance the County-Hospital-Eger-1973 [80] and the OTKI-1970 [226] studies. Although I managed to speak all but one researcher personally, it turned out that the databases of most previous studies have either been disposed of, or are not available for secondary analysis. This has reduced the number of studies to three, which I finally managed to retrieve from the database archive of the Social Research Informatics Center (TÁRKI). Hence secondary analysis has played only a complementary part in our study.

The OTKI-1984 study has been considered as a source of evidence on the magnitude, distribution, and impact on equity of informal payment, while the TK-1985 and TÁRKI-1996 studies also address these issues and clarify the motivation of actors. The major features of all three pieces of research have already been summarised in Tables 4.2 and E1.

The analysis involved identification of relevant variables and specification of associations to be explored, with data analysis using SPSS. On the basis of the original questionnaires we expected to identify overall amounts of informal payment (OTKI-1984;TK-1985), their distribution according to the types and levels of care (TK-1985;OTKI-1984;TÁRKI-1996), and between physicians and other health workers (OTKI-1984;TK-1985). In terms of equity, assessment of the cost burden imposed by informal payment seemed particularly relevant. Both the OTKI-1984 and the TK-1985 studies date from before the 1988 tax reform and, according to Bondár & Ékes [75] information about the income of respondents was much more reliable prior to this reform. Finally, we expected to obtain evidence about motivation, especially from the TÁRKI-1996 study, which posed an open-ended question, but used the same coding scheme as the OTKI-1972-73 and 1981 studies.

5.4.2. QUALITATIVE INTERVIEWS

The literature review suggests that in testing the validity of the ‘donation’ hypothesis the motives of patients are of the utmost importance. The literature review also suggests that the current inconclusive findings are attributable to the inability of surveys accurately to reflect the complexity of motivation. We have tested this idea by identifying cases who stated that they paid because of ‘gratitude’ and/or ‘custom’ (‘non-coercive’ reasons of giving), from our household survey, and later

interviewed them personally in a loosely structured way to explore in detail the context of informal payments. We have assumed that the decision to pay the physician informally does not take place in isolation, and specifically is not disconnected from previous experiences with health care. Thus the objective of qualitative interviewing was to gain insight into the context of giving and identify factors that predisposed to informal payments as opposed to the concept of voluntarily giving thanks. From this respect, we have considered the perspectives of physicians equally important, although it was not possible to identify with certainty those who participated in these transactions.

Box 5.1. Qualitative interviews	
Objectives	to explore the context of giving
Unit of analysis (observation)	individuals
(Study) population	patients, practising physicians
Sampling method	purposive (theoretical) sampling
Sampling frame	household survey, management of health care institutions
Sample size	15+6 patients, 22+9 doctors
Method of data collection	in-depth interview, observation
Topics, questions	motivation (Q6)
Implementation	07/2001-10/2001
Interviewer	Péter Gaál
Analysis	Cross-sectional and contextual indexing of transcripts and notes

5.4.2.1. Sampling

The unit of observation has been the individual, and the study populations were patients who utilised health services and practising physicians. Practising was defined as those who were working in patient care during the course of the research regardless of the level of care and speciality or service.

We selected patients from those who responded to our household survey. All those who reported paying and attributed this either to gratitude or custom, or a combination, were considered for follow-up interview. However, out of the 21 cases, only 11 interviews were possible as 6 persons refused to participate, 1 person could not be contacted and in 3 cases it was not possible to find a mutually suitable time for the

interview. However it was also possible to interview a further four who raised relevant issues with the interviewers during the survey. Of the additional four, one commented that *“it was a pity to give gratitude payment beforehand”*, another indicated to give because of ‘custom’ and ‘enforcement’ at the same time, and two others used both public and private services, and were dissatisfied with the former. All together I therefore interviewed 15 patients, whose demographic and socioeconomic characteristics are summarised in Appendix B. Furthermore, the interviews of 6 other patients, who were interviewed within the frame of a case study on private sector informal payments, have also been included in the analysis.⁴⁰ Their demographic and socioeconomic characteristics are presented in Appendix C. This raised the final sample size to 21.

The second set of interviews was with physicians. As discussed earlier, they were not linked directly to patients from the survey, but they were service providers in the town where the household survey was conducted. The head of the health department of the local government facilitated the sampling process, introducing me to the management in the relevant health care institutions (two hospitals, one ‘county’ and one ‘town’ and the health department itself that provided primary care). Altogether I interviewed 18 physicians from Kecskemét. The sample was designed to ensure inclusion of a broad range of medical specialties, but to broaden the type of institutions covered, the sample was supplemented with four other doctors chosen from university hospitals and national institutes of health. Thus the final sample comprised 22. However a further set of interviews with 9 more physicians was also conducted within the framework of a case study on private sector informal payments, making a total of 31 physicians interviewed overall during this study. Appendix B provides a description of the age, sex and specialty distribution of the physicians interviewed.

5.4.2.2. Data collection

Qualitative interviews were used, with the objective of exploring the context in which the decision to pay the physician informally was made, as we have assumed that this decision is shaped by a number of contextual factors, without recognition of which it is not possible to understand why patients pay for services that would otherwise be free of charge. Clearly the literature review suggested what these factors might be, but one objective of the interviews was to identify these more concretely, focusing on the

⁴⁰ The preliminary findings of this study are presented in Appendix I. We could not include this analysis in the thesis because of space constraints.

concept of the ‘coercion’ factor, which we developed in Appendix F. Thus, I constructed the interview schedule in a way that would allow sufficient flexibility to develop the interviews on site, both in terms of the depth with which a particular issue was studied and the range of issues covered. These interview schedules are presented in Appendix B. Nevertheless, both the patient and the physician interviews had certain core topics, which formed the backbone of interviews.

Interviews with patients centred around the disease episode and treatments received, where informal payment had been made. This proved to be a good strategy, as I always came to the topic of informal payment without explicitly raising it. Part of the strategy was to explore previous experiences when obtaining health care and to ask the respondents’ opinions about the performance of the system in general. Furthermore I deliberately did not pursue the issue of motivation directly (unless the respondents brought it up), as I would not have wanted to confront the respondents with their previous answer in the survey, or to linger on any potential ambiguity in their accounts of events (this is not an issue of ‘right’ or ‘wrong’ answers).

In a similar vein, I began the interview with physicians by exploring their work experiences, and their opinion on the functioning of the health care system. With almost no exceptions this brought up the issue of informal payments without asking, which provided a lead to continue exploring their experiences of the phenomenon that, in this case, included the question of ‘why people pay’. Both patient and physician interviews covered the question of alternative options (exit and voice), but this topic has not been included in the analysis, because of constraints on thesis length.

At the beginning of each interview I introduced myself, briefly explained the aims of the research and emphasised that as participation was voluntary, the interview could be terminated at any time, the respondent could refuse to answer any questions, and the respondent’s identity was strictly confidential and anonymity would be preserved. I also asked for permission to record the interview using a dictaphone, and offered the alternative option of hand-writing instead. In any case, I was prepared to make notes during the interview. Overall only 8 interviews were not tape-recorded.

I carried out all the interviews personally, between July and October 2001. The administrative staff of the Health Services Management Training Centre prepared the draft transcriptions between November 2001 and March 2002.

5.4.2.3. Analysis

The analytical strategy has been centred around the concept of ‘coercion’, and comprised two equally important elements combining cross-sectional (categorical) and contextual indexing [239,pp.147-172]. First, using all available interviews, we searched the material to identify particular factors that lead patients to pay informally. Second, using only patient interviews, we tried to identify factors that played a role in cases payment seemed voluntary (i.e. the stated motivation was either gratitude, or custom, or both).

5.4.2.4. Limitations

According to the post-positivist framework, there is a trade-off in terms of validity and reliability between the employment of qualitative and quantitative methods [84]. In-depth interviews are only loosely structured and the dynamics of the interview influences the data that are generated by the interview. Furthermore the personality of the interviewer also impacts upon the process as well as on the analysis and interpretation of the data. These limitations of qualitative interviewing, however, cannot be overcome without sacrificing the very essence of the research method itself. The standardisation of the interview process in itself does not ensure that there is a shared understanding of concepts and leaves less room for exploring discrepancies in understanding. While the analysis and interpretation of qualitative interviews depend on the researcher, and it can be argued that there are not better or worse but just different interpretations [244,pp.201-202], in our case it is possible to challenge the correctness of interpretation of the data by looking at the transcripts of actual interviews. Furthermore, in most cases, they are also available in audio files.

The other limitation of in-depth interviews is that it is very difficult to establish external validity. Both the selection of interview subjects and the small sample sizes (because of the demanding nature of the undertaking) limit the generalisability of findings. Although representativeness is not always essential in qualitative interviewing, in this study we have taken steps to achieve some degree of representativeness. The bulk of patients have been selected on the basis of the household survey, while in selecting physicians, we have taken into account not just medical specialties and levels of care, but the age and sex of interview subjects.

5.4.3 HOUSEHOLD SURVEY

The household survey, certain parts of which have been integrated into the present study, was implemented in the framework of an international collaboration, with the participation of 5 academic institutions and 4 survey sites, in the Czech Republic, Poland, Romania and Hungary. The loss of funding from the Ministry of Welfare project could thus be overcome, but it also imposed some constraints. We had to reassess what could be realistically achieved within the limitations the study

design entailed. The objective of the study was to estimate the magnitude and distribution of all out-of-pocket payments, and had a predefined core questionnaire, used previously in other studies, which limited to what extent informal payments could have been addressed. Further, the research team has decided that the study population would be households in a medium-sized town in each country, and that the questionnaire would be administered by the telephone, mainly for financial reasons. Both of these design features inevitably reduced the external validity of the research. Nevertheless, they did not decrease the ability of the survey to address the motivation issue and to identify cases for qualitative interviewing and, despite the limited generalisability, findings concerning the impact on equity of informal payments would be valuable, as this research area was virtually unexplored in Hungary.

Box 5.2. The household survey	
Objectives	to explore the phenomenon in the 'pure' private setting
Unit of analysis (observation)	household
(Study) population	households of Kecskemét
Sampling method	random
Sampling frame	household addresses provided by the Central Population Registering and Electorate Office
Sample size	817 out of 930 households (87.8%)
Method of data collection	structured interviewing (questionnaire) by telephone
Topics, questions	equity (Q3,Q4), motivation (Q5)
Implementation	02/2001-06/2001
Interviewers	10 trained interviewers
Analysis	SPSS

5.4.3.1. Study population

As an example of a medium-size town, we chose Kecskemét, which is the 8th largest among the 19 county-seats in Hungary, with 105,000 inhabitants [23]. It is located in the centre of the country (Figure 1.1). One reason for selecting Kecskemét is that it has a densely populated urban core, and a surrounding area of small farms and 8 villages, thereby covering a mixed rural-urban population. Although, while there are some similarities, the population of Kecskemét is not representative to the country as a whole, as a more detailed analysis in Appendix D shows. The most marked differences are that

Kecskemét has a more educated population with fewer blue-collar agricultural workers, fewer unemployed people, and fewer poor households compared to the country as a whole. Further, households with two or more families, and larger households with 5 persons or more are underrepresented, while 2-person households are over-represented, so there is a slightly smaller average household size than in the country overall. Further comparison is limited as other important household attributes, such as health status, household income and expenditures are not available in the published statistics for Kecskemét.

5.4.3.2. Sampling frame

After the consideration of the available options, we obtained a random sample of 1,500 households in Kecskemét, from the Central Population Registering and Electorate Office, and identified those households with a residential telephone line from public directories. This way we could avoid certain sampling biases arising solely from the use of telephone directories (e.g. households with more than one line, or the same household number listed twice). Further, this method offered the possibility of carrying out additional face-to-face interviews with households where there was no telephone. Unfortunately this was not implemented due to financial constraints.

The chosen method of sampling could not eliminate another sampling bias. As the sampling was based on residential addresses, households, who shared the same accommodation, had less chance to get into the sample. However, there was no other option available which could have eliminated this bias (see Appendix D for a more detailed discussion of these issues).

5.4.3.3. Sample size and characteristics of the sample

There were 930 telephone numbers, which were valid and could be contacted in the course of data collection, and 113 persons refused to participate in the survey, giving a response rate of 87.8%. The interviewers were asked to record the gender of the non-respondent and to ask about the reasons for refusals. We have gender information on 56.6% of non-respondents, 53.1% of whom were women and 46.9% were men. Although many interviewees (34.5%) did not provide a reason, some refusals were directly associated with the topic (being a health worker, bad experiences with the system). Table D9.0 in Appendix D provides a more detailed analysis of the reasons for non-responses. In addition 9 respondents broke off questioning in the middle of the interview, but these incomplete questionnaires have been included in the analysis.

Unfortunately the responding households were quite unrepresentative of the population of the town and, to a lesser extent, of Hungary (see Appendix D for a detailed analysis). The most notable differences are that responding households are larger, and more active economically. One obvious explanation may be that differences are attributable to the possession of domestic telephone line, but this requires further investigation.

Over two-third of the responding persons were women (68.5%), and just over half of them (51.4%) fell into the 19-45 age category. Nineteen respondents were under the age of 19 (1.1%), and 14.5% of them were over 60. The rest of the responding persons (14.5%) fell into the 46-60 age category (see Table D10 in Appendix D).

5.4.3.4. Data collection

The international research team chose the method of data collection, i.e. structured telephone interviews, but not simply because this was less expensive. In a previous study in Krakow, Polish researchers achieved an impressive response rate using the telephone. While, in general, face-to-face interviews are regarded as yielding the highest response rates compared to postal questionnaires and telephone interviews, the response rates in this study is encouraging. Nonetheless, as we have mentioned before, it is not possible to get a representative sample using this method unless telephone coverage is complete and all numbers are in the public domain. A low level of telephone coverage was a problem during the communist dictatorship, but the past ten years brought rapid improvements. In 2000, telephone coverage in all the larger cities, including Kecskemét was over 80% [251].

The research team developed a common questionnaire in order to allow a meaningful comparison of results between countries. A core questionnaire was drafted and piloted in each country. On the basis of the experiences of the pilot study, the questionnaire was refined. This does not mean, however, that the country questionnaires were identical. The model or 'core' questionnaire was able to be modified to fit the specificities of individual countries.

In Hungary, the telephone interviews were carried out over a four-month period, between February and June 2001. Altogether 10 trained interviewers participated in the survey, as well as the principal researcher, who undertook the training sessions. The interviewers were university students and colleagues at the Health Services Management Training Centre. Each interviewer was given a list of telephone numbers which were called during weekdays, usually between 6 and 9 pm, and during the

weekend all day. Non-answering numbers were tried at least twice per week (weekdays and weekends) over the period of data collection.

5.4.3.5. Questionnaire: the operationalisation of informal payments

As we have discussed in chapter 3, informal payment can be operationalised either by asking the patient directly to separate informal from formal payments, or by asking respondents, how much they spent on different types of services and different types of providers, and by distinguishing informal payment during the analysis, using knowledge of the entitlement to services in the health care system concerned. Although both methods are open to miscategorization, we have opted for the second method for two reasons. First, as Appendix D shows, formal co-payments are still negligible for services in Hungary, and what exists is determined centrally, which makes it feasible to distinguish them. Second, we have been suspicious that there is no shared understanding of the widely used term, ‘gratitude payment’. Third, informal payment has proven to be a sensitive question and the use of neutral categories might facilitate a better response rate.

The questionnaire, reproduced in translation in Appendix D, had two main parts. The first part was related to the households, including questions regarding the basic socioeconomic characteristic of the household, such as number of members, their sex, age, marital status, education, occupation, the income of the household and certain general questions about attitudes towards out-of-pocket payments. The interviewer filled in one questionnaire per household.

The second part of the questionnaire comprised different questions regarding each type of health problem that had affected the household in the previous four months. Health problems were separated into two categories: diseases, and utilization of health services for other reason than disease. Respondents were asked to name the disease or the reason for utilization. If the episode involved a disease, the respondent was asked whether any health services had been utilized, and if not why. For all cases of health care utilization, including those not involving treatment for a disease, the service received was recorded along three dimension: (1) the type of provider – primary, outpatient specialist, inpatient, emergency, diagnostic, dental and other care, (2) the ownership of the provider – public or private, (3) the financing of care – public or private. Then three questions were posed on out-of-pocket payments: one for cash payments, one for gifts and one for in kind contributions. In the case of cash payments and gifts various categories were offered, linked to each provider used during the

episode. These were admission, consultation, pharmaceuticals, surgery, nurses and other health care staff, patient transfer, travel, food and other services.

In the course of the analysis, the information on health care providers, and the information on payment for various service categories were used to separate the formal from the informal. The process is described in more detail in Appendix D.

Although we cannot be certain that this method has avoided misclassification entirely, any misclassification that occurred is likely to have underestimated informal payments.

5.4.3.6. Analysis

The completed questionnaires were processed electronically. Data were entered into four different databases, according to the units of analysis (households, members, disease episodes, health care utilisation episodes) using Microsoft Access, which made it possible to link the separate databases by means of identification numbers. The software also made it possible to carry out extensive data cleaning and quality control processes, using the control questions, and the internal logic of the questionnaire. The statistical analysis was carried out using SPSS.

5.4.3.7. Limitations

We have already touched upon some of the limitations of the survey design, such as the choice of the study population (medium sized town, not the whole country), the sampling frame (two and more households under the same roof had less chance to get into the sample) and method of data collection (households with no domestic telephone lines or with secret numbers has been excluded), which limits the generalisability of the findings of the survey. These can be considered significant defects in terms of estimating the scale of payments, so we did not rely our estimate on the findings of our survey. Refusals to participate in the survey have most probably also biased the findings insofar as, in a few cases, the reason for non-response was associated with the subject of the study. We have also identified some respondent bias, as in a few cases the interviewee admitted giving, but refused to tell the amount. However it is not possible to tell the exact scale of respondent bias, since there could have been respondents who denied payment; neither can false declaration of informal payment be excluded with certainty. Furthermore, responses might have been affected by recall bias as interviewees had to remember past events of health care utilisation, and not just for themselves, but for other household members. We have deliberately selected a

period shorter than a year to minimise this sort of bias, and the questions that had to be asked for each episode of health problem and health care utilisation might have also facilitated the recollection process. Although one can not say that these design features have totally eliminated recall bias, it has probably affected less serious health problems with minor out-of-pocket payments. Nevertheless, choosing a four-month period might have caused another bias, as there are seasonal variations in the scale and types of disease episodes. This type of bias, though, may have been mitigated by the fact that the interviews were carried out over a four and a half month period.

We have also mentioned that misclassification of out-of-pocket payments might have caused an underestimation of informal payments. The estimation of in-kind contributions has been problematic because of a weakness in the questionnaire (the questionnaire did not capture in kind contributions, if no out-of-pocket payments were paid). Data quality could have also been affected by mis-recording both in the phase of interviewing and data input. As it has been mentioned before, we have carried out extensive data cleaning, but we also tried to limit data input errors by designing a user-friendly data input interface in Microsoft Access.

5.4.4 REVIEW OF OFFICIAL STATISTICS

To establish the importance of informal payment in terms of its scale, we used mainly the regular HBS of the HCSO, but we also managed to obtain some basic statistics from the Tax Office on the overall magnitude of ‘gratitude payments’, based on tax return data. Although we suspected in advance that there would be substantial differences between assessments of income and expenditure, we felt it important to confirm this.

As discussed before, one possible drawback of official statistics is the quality of data that can be obtained. To address this concern, we tried to explore the methodological basis of the household statistics as deeply as possible by interviewing those involved in the implementation of the surveys. I personally spoke to the head of the department, who provided me with the background documentation on the research, for instance the standard diaries used by the households to record income and expenditures, and the questionnaire for yearly expenditures (such as consumer durables), and to the person responsible for the health care section of the survey. She provided me with valuable information on methodological issues, including recent changes in the method of addressing health care expenditures. These will be discussed in chapter 6, where the official statistics are analysed to address to scale of informal payments.

5.4.5. DOCUMENTARY ANALYSIS

Documentary analysis was originally planned to establish the availability of the exit and voice options, by exploring the legal background of these options, past changes and future plans. Many of the relevant documents, laws and regulations, policy documents, and where relevant, newspaper articles have been collected, but not included in the analysis because of space constraints. Thus apart from the analysis undertaken to prepare the description of the Hungarian health care system and health sector reform (chapter 2), documentary analysis will be carried out as part of future research in the area.

5.5 Conclusions

Drawing on a modified post-positivist epistemology and within the confines of feasibility, ethical and political considerations, this study has utilised a mixture of quantitative (official statistics, surveys) and qualitative (qualitative interviewing) methods to generate evidence to address a modest research agenda, which has the policy importance of informal payments for health care in its focus. Focussing on the contrasting implications of the ‘donation’ versus the ‘fee-for-service’ explanation, the research has to explain the motivation of participants (both directly and indirectly) and to assess the magnitude and distribution of informal payments. In selecting the various research methods to address these topics we have considered their limitations. We have considered the external validity limitations of the survey sufficiently serious enough not to rely upon it for assessment of the scale of informal payments. In other cases, such as the equity of informal payments and motivation of patients and doctors, we will consider the impact of these limitations on the validity of the findings.

In the following chapters we will present the main findings of the study, synthesise and confront them with the ‘donation’ explanation.

CHAPTER 6.

6. MAGNITUDE AND DISTRIBUTION OF INFORMAL PAYMENT

The aim of this chapter is to establish the scale of informal payments. As we have argued previously, it is immaterial whether informal payment is ‘fee-for-service’ or ‘donation’ if the amounts are so small that they do not put a real financial burden on the poor and they represent only a minor source of income for health workers, especially physicians. However, we were unable to establish the scale of informal payments from the existing information, noting that reports of the overall magnitude of the phenomenon have been contradictory. Although we did not seek to obtain a precise figure, our review of the available evidence in chapter 4 found a difference of an order of magnitude between different survey estimates and between empirical data and expert estimates.

6.1. Outline of the chapter

In order to resolve these contradictions, first we will attempt to at least to clarify the order of magnitude of informal payments, using available official statistics, as described in chapter 5, assessing critically the findings in relation to the methods used to collect these data. Then we will examine the distribution of informal payments, using findings from previous surveys, which were shown in chapter 4 to exhibit a remarkable degree of consistency about this issue at least. We consider knowledge of the distribution of informal payments crucial to assess the impact on the system of informal payments, since a relatively small amount of money could have a substantial impact on some individuals. For instance, as Chawla et al [204] have reported, the overall sum accounted for by informal payment in a year was estimated to be only 10% of the gross salaries of all hospital personnel in Poland in 1994, but equivalent to twice the annual salary bill for physicians. Thus, to establish the importance of the phenomenon in terms of its scale, we will compare the income from informal payments with the official salary of physicians, first by establishing the best estimate of its overall magnitude, and second by modelling a plausible distribution of the sum among health workers and within them, physicians. Both steps of the analysis will be complemented by secondary analysis of previous surveys and by the findings from our household survey, while recognising the limitations of these studies as discussed in chapters 4 and 5.

6.2. 1, 10 or 100 billion? The overall magnitude of informal payment revisited

To assess the overall magnitude of informal payments we have analysed available official statistics, both in relation to income and expenditure. This section relies primarily on the household budget survey (HBS) of the Hungarian Central Statistical Office (HCSO), which has collected data on gratitude payment from both payers and recipients, within the framework of the same study, annually, since 1992. Before 1992, the survey was conducted only every other year and gratitude payment was not separated from formal out-of-pocket expenses on health services, except in 1983, when the general survey was complemented with a detailed health care specific component. Then we compare these data with survey findings identified in chapter 4, critically assessing the methods used to identify their limitations and consequent impact on the validity of the final figures. This will then allow us to determine the range in which the ‘true’ magnitude of informal payment lies.

6.2.1. INCOME-SIDE ESTIMATES

We have analysed data from two official sources. First, in the framework of the HBS, the HCSO regularly collects data on both the income and expenditure of a nationally representative sample of households in Hungary. Second, as we mentioned in chapter 2, the recipients of informal payments have been required to declare these types of income in their tax returns since 1989. We have asked the Hungarian tax office (APEH) to provide us with the available data and their Department of Planning and Analysis not only acceded our request, but they also volunteered information on the history and known shortcomings of the taxation policy. Table 6.1 presents the data obtained from both sources. They include not only informal payments for health care, but income from tips in all other sectors of the economy.

Table 6.1 well illustrates the point raised, for instance, by Ékes [223] and Lewis [96], that recipients of informal payments are an unreliable source of data, even if the questioning is not related to income taxation. If we compare these estimates with the findings of expenditure surveys presented in Table 4.3, even the highest figure among the former is almost half of the lowest figure of the latter. Given that both types of income estimates include tips unrelated to health care, this difference is certainly higher for informal payments for health care alone.

Table 6.1 also illustrates how the taxation policy failed. Over the 9 years when information on gratitude payments and tips was collected separately in the income tax

declaration form, the number of persons admitting to have such income in the previous year decreased substantially, with the figure in 1996 less than one-third of that in 1988. Since 1998 (relating to income in the calendar year 1997) there has been no separate line in the tax return and the official instructions no longer mention “*medical gratitude payment*” as an example. The attempt to tax informal payments yielded a negligible amount of revenue, even in the early years of the policy, when the most strenuous efforts were made to enforce compliance [8], although the tax office admits to technical difficulties limiting such efforts. For instance, it was not possible to identify practising physicians from the tax returns forms, so the audits targeted only those doctors, who were well known by name. Furthermore, Ádám [8] argued that there was a more fundamental, legal obstacle going beyond the ‘legal-illegal’ debate. According to *Act II of 1972 on Health* [252,75] health workers were forbidden to provide better services to one patient compared to another; consequently gratitude payment should have been considered not to be tips but gifts, which were not the subject to income tax.

Table 6.1. Income-side assessment of informal payments in Hungary

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
HCSO data*													
Per capita income from gratuities and tip (HUF)	-	n/a	-	n/a	n/a	54	82	49	149	167	123	156	n/a
Overall magnitude per year (billion HUF)*	-	n/a	-	n/a	n/a	0.546	0.828	0.495	1.504	1.683	1.236	1.562	n/a
Tax office data**													
Number of persons declared income from gratuities and tip	68,406	63,150	56,023	52,449	45,569	39,755	33,870	29,567	21,621	n/a	n/a	n/a	n/a
Overall magnitude per year (billion HUF)	0.827	0.768	0.685	0.799	0.740	0.781	0.716	0.681	0.614	n/a	n/a	n/a	n/a

Notes: n/a=not available
Source: *Calculated from data of HCSO's HBS [253; 76; 254-257; 27]; **[258,06-12-1999]

6.2.2. EXPENDITURE-SIDE ESTIMATES

As we have seen in the previous section, assessments based on data provided by health workers underestimate the overall magnitude of informal payments. Although this conclusion fits well with the general observation that people are more willing to reveal their expenditures than their income, one can argue that it is possible that differences between the findings of expenditure surveys and official statistics on income are attributable to the differences in methods of data collection, and this does not exclude the possibility that other surveys have overestimated informal payments. Table 6.2, which summarises expenditures on informal payments according to HBS, resolves this doubt. The difference between the income and expenditure assessments in the same

survey, which used the same method of data collection and the same households, is equally substantial. This suggests that the expenditure assessments indeed provide better estimates of the overall magnitude of informal payments. Consequently we have based our analysis on findings of expenditure surveys, particularly the HCSO HBS.⁴¹

Table 6.2. Overall magnitude of informal payments per year in Hungary according to various sources (billion HUF)

	1983	1986	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Household budget surveys of HCSO*	1.398		n/a	2.440	3.875	4.313	4.666	5.271	5.775	5.900	7.890	9.037	17.122
National Health Accounts of HCSO**										13.400	16.400	20.900	
Keckskemét-survey													13.033
Other expenditure-side surveys***													
GKI-1986		2.000											
SZGTI-1992				7.300									
SZGTI-1994						7.407							
KSH-1997 (HCSO)									3.028				
TÁRKI-1998										33.000			

Notes: n/a=not available
Source: *Hungarian Central Statistical Office, partly own calculations [259-261; 253; 76; 254-257; 27; 262; 263]; **[264]; ***[200; 223; 75; 225; 214]

However, as Table 6.2 shows, there are substantial differences between the estimates of the HBS and other expenditure surveys (with the possible exception of 1983), the HBS and the recently published National Health Accounts (NHA) of the HCSO or the HBS data for 2000 and 2001. The source of these differences, especially where there are divergent estimates for the same year, must be methodological, offering a possibility to understand to what extent differing research methods can explain the differences in the various surveys and in turn try to assess where the ‘true’ magnitude of informal payment most probably lies.

6.2.3. HOW MUCH? 100. WHAT IS 100? WHAT IS HOW MUCH?

To identify the cause of the differences discernible in Table 6.2, we have looked in more detail at the research methods used. First, there is a more or less detailed

⁴¹ Originally we planned to complement published findings and the official statistics from the HCSO with the secondary analysis of the OTKI-1984 study, but to our surprise the database we managed to obtain only contains limited data on informal payments. Furthermore, we have discovered a more fundamental methodological problem with all three studies whose databases have been available for secondary analysis. The OTKI-1984 and TÁRKI-1996 studies addressed only the last episode of hospitalisation within three years prior to the interview, while the TK-1985 study addressed only those health care utilisation episodes that were associated with the disease that involved the most intensive utilisation of any level of care within the past “couple of years” prior to the interview. These shortcomings limited the usefulness of secondary analysis, especially concerning the assessment of the overall magnitude of informal payments.

methodological supplement for each set of HBS statistics, and there are methodological sections in the publications of the other surveys. Second, as far as possible, I sought to contact the heads of the research teams or the officials responsible for the research projects.⁴² I learnt that the NHA estimates (first published at the end of 2002 for the period of 1998-2000) have been based on the HBS data and drawn on adjustments made in relation to the calculation of national income (the 'big' national accounts project), but the exact method of correction is, unfortunately, not in the public domain. Consequently, the NHA data on informal payments have been of little use for our analysis.

As we discussed in chapter 5, the HBS uses the 'time-budget' technique of data collection, whereby households record their income and expenses in a diary, with the recorded items summed after the data collection period according to predefined categories. The HCSO selects about 10,000 private households each year (i.e. institutions, such as residential homes for the elderly, Hungarian citizens living abroad and foreign citizens living in Hungary are excluded), producing a sample of about 0.25% of all households in Hungary [263,pp.241-244]. Nevertheless, respondent households do not have to keep the diary for the whole year. The sample is divided into twelve equal parts and each has to record household income and expenditures for one month only. In addition, there is a two-part annual interview for the whole sample, first at the beginning of the subsequent year and then at end of the first quarter of the subsequent year, to collect data on personal and family incomes and a number of exceptional expenditure items, such as cars, household electric appliances, computers and mobile phones. The rationale for using an annual interview is not just the rare occurrence of these events but also the seasonal variation in certain types of expenditures [263,p.244].

In principle this study design should be suitable to obtain an accurate picture of health expenditures, but the implementation of the survey has posed difficulties, some

⁴² Specifically I have contacted Dr. Mária Rédei (head of the Household, Income and Consumption Statistics Section of the Living Standard and Human Resources Statistics Department of HCSO), who kindly provided me with general methodological information on HBS and research documents, including the household diary and the coding booklet, and the materials of the KSH 1997 'hidden economy' study; Zsuzsanna Szabó, who is responsible for the health section of the HBS and has explained to me the methodological problems and relevant changes in estimates of household health expenditures, and provided me with the most recent research materials used in 2000 and 2001; and Dr. Mária Mannó, who has been member and currently the head of the NHA team and provided me with basic information about the method of the estimation of the overall magnitude of informal payments within the frame of the NHA project.

of which have been addressed in different years, both in respect of data collection and analysis.

6.2.3.1. Selection and respondent bias

Participation in the HBS is voluntary, so refusal to participate in the survey has always been a challenge, particularly since the collapse of the communist regime, which widened social inequalities and decreased willingness to cooperate [27,p.359]. Table 6.3 shows that response rates decreased until 1997. In 1996 almost 40% of the 12,135 available households that were requested to participate refused to keep the diary. The most important reasons for refusals, a lack of time and distrust in the HCSO, imply that rejections are associated with personal and household attributes such as economic activity that inherently influence both the income and expenditures of households and so potentially introduce bias. What information on refusals exists reveals not only regional variations, but substantial differences in terms of economic activity of the head of the household [27,pp.372-377].

Table 6.3. Refusals and response rates in the household budget surveys

	1983	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Number of households approached		14,376	7,530	13,327	13,891	16,304	13,702	13,085	17,601	17,311	17,243	16,631
Refusals				3,505	4,112	4,092	4,604			4,897		3,949
Of which lack of time										37.8%		42.8%
Of which distrust										39.2%		42.0%
Other reasons of failure (empty flat, moved, etc.)				1,716	1,853	1,630	1,567			2,229		2,392
Final sample size	3,878*	11,813	4,911*	8,106	7,926	10,582	7,531	7,560	10,144	10,185	10,191	10,320
Response rate for one-month diary keeping												
Including all failures		82.2%	65.2%	60.8%	57.1%	64.9%	55.0%	54.7%	57.6%	58.8%	59.1%	62.1%
Including refusals only				69.8%	65.8%	72.1%	62.1%			67.5%		72.3%
Refusal of annual interview			270						128	147	155	285
% of final sample			5.5%						1.3%	1.4%	1.5%	2.8%
Other reasons of failure of annual interview									212	221	191	356
Response rate for annual interview									96.6%	96.4%	96.6%	93.8%

Notes: *Only 50% of the original sample of households kept a diary on detailed health expenditures [259,p.161]. *The data collection period was 6-month only.

Source: HCSO's HBS, partly own calculations [259-261; 253; 76; 254-257; 27; 262; 263]

To overcome this sampling bias the HCSO has acted in two ways. First, they have introduced sample adjustments using corrective weights on the basis of census data. Between 1993-1998, only demographic (age group and sex) correction was applied but this was extended in 1999 to include economic activity and education of household members [27,pp.350,360-369]. Second, the HCSO has begun to implement measures to

increase response rates, for instance, in 1999 increasing the remuneration of interviewers [27,pp.374,377], a policy that does seem to have made a difference (Table 6.3).

In addition, partial non-responses and respondent bias, especially in relation to income, have also been dealt with since 1999, using various methods of “*imputation*” [27,pp.370-372; 263,pp.245-248]. For instance, in the case of missing annual interviews, data are substituted with the average expenditure of respondent households, and this amount is assigned to non-respondents randomly according to the average frequency of the occurrence of the expenditure item in question. The income of the self-employed is inflated to be comparable the level of their household expenditures.

Nevertheless, there is little evidence that any of these adjustments has made a difference in terms of estimates of health expenditure. In 1999, when these additional corrections were introduced, the same adjustments were applied to the data from the 1998 survey. Table 6.4 shows that there is hardly any difference between adjusted and non-adjusted figures for 1998. This suggests that these types of selection and respondent biases have not distorted household expenditures on informal payments.

Table 6.4.

Comparison of original and adjusted health expenditure data of the household budget survey for 1998 (yearly per capita expenses in HUF)

	Original health expenditures*	Adjusted health expenditures**
Pharmaceuticals	5,582	5,507
Medical aids and prostheses	787	768
Health services	1.073	1,043
Informal payments	591	587
Total	8,033	7,905

Notes: *Only demographical correction was applied on the sample using updated census data by counties, age groups and sex.
 **Imputation of annual expenditures in the case of partial non-responses, and extended sample correction, including age, sex, education and economic activity of household members on the basis of updated census data.

Source: *[257,p.37]; **[27,p.37]

It is true, however, that these adjustments are not able to address all elements of selection and respondent bias. For instance, there is some indirect evidence that households with really high incomes are underrepresented in the sample, because refusals are higher among them than among households whose head has the same level of education and economic activity, but lower income. Furthermore, these methods of data correction are not able to eliminate distortions from suppression and concealment of some forms of income and expenditure [27,pp.362,368-369].

Both of these problems might have an impact on the estimation of the overall magnitude of informal payments, although to differing degree. Higher income implies a

higher overall expenditure and within that health expenditure, but also better health status and consequently fewer and less serious diseases. Further, the really wealthy can afford to pay for private health care, which might be a more attractive option than informal payment to public providers, insofar as the former offers a more secure basis for higher quality care.

Table 6.5. Refusals and informal payment related non-responses in other surveys

	OTKI- 1972-73	DOTE- 1973	OTKI- 1981	GKI- 1986	KSH- 1997	TÁRKI- 1998	Kecskemét- study-2001
Response rates	44.4%	92.2%	53.6%	84.4%	93.2%	n/a	87.8%
% of respondents refused to answer questions on informal payments	3.9-11.3%	19.6%	18.5-19.2%	1.4%	n/a	n/a	-
% of respondents, who paid, but refused to tell the amount	1.3-7.7%	?	?	-	-	n/a	0.5%

Notes: n/a=not available; ?=It is not possible to tell, whether the survey design allowed to make this distinction.
Source: [78; 190; 228; 200; 225; 214, and own survey]

Concerning the concealment of informal payments, there is evidence from previous surveys that the sensitivity of the topic resulted in substantial non-response (Table 6.5). Although not all relevant information has been published, it seems that non-responses were more of an issue during the 1970s and 1980s than in the past decade. For instance, the report of the KSH-1997 “*hidden economy*” study mentions, among other topics, gratitude payments to physicians as a “*sensitive area*”, for which “*not everybody answered fully truthfully*” [225,p.101], but does not say that such dishonesty has been any more extensive for informal payments than for any other item. In contrast, in a very similar ‘hidden economy’ study (GKI-1986), Ékes [200,p.6] experienced higher non-response in relation to medical gratitude payments than most other items. Further, in the TÁRKI-1998 study, Bognár et al. [214,pp.28-30] extensively discuss factors that influence estimates of the overall magnitude of informal payments, but they do not mention non-response as a problem at all. This suggests that non-response may not have been an issue in their survey. Finally, in our Kecskemét survey we encountered such cases, but they represented only 0.5% of participating households whose members had utilised health care.

It is not possible to assess the extent of respondent bias in HBS, because households simply do not record in the diary expenditures that they would like to conceal and before 2000 health expenditures were not part of the annual interview. Although health expenditures have been addressed in the framework of the annual interview since 2000, there is no published information on non-responses related to informal payments, but if

our assumptions are correct, non-responses in respect of informal payments for health care are less of a problem now than previously. The incorporation of health expenditures in the annual interview, however, has uncovered two specific problems that are likely to have caused a massive underestimation of the overall magnitude of the phenomenon before 2001: miscategorisation and the limited ability to capture infrequent expenses. The step by step methodological changes allow us to assess the effects of these problems.

6.2.3.2. Misclassification of health expenditures

In the HBS, households record their expenses in a diary that does not contain predefined categories for non-regular expenditures, and the items in the diary are sorted into expenditure categories by coders after the data collection period. Until 2000, health expenditures were allocated into four main categories in the coding phase: pharmaceuticals, medical aids and prostheses, gratitude payment and health services (out-of-pocket payments to private doctors/providers). While medical products (such as hearing aids, wheelchairs and various drugs) can easily be distinguished from out-of-pocket payments to service providers, such distinction between gratitude payment and payments to private providers is not straightforward. It is not possible to tell whether the expenditure was formal or informal from notes such as ‘doctor – 1000 Ft’ [265]. This suggests that informal payments could have been underestimated if ambiguous items had been placed in the category of ‘health services’ and not ‘gratitude payment’.

Table 6.6 shows evidence that such misclassification may have occurred in the HBS. Expenditure on gratitude payments and health services individually exhibit marked changes from year to year, while with the exception of 2000, changes in the sum of, gratitude payments and health services are under 20%. In 1983, when the HBS was supplemented with a health care specific component, half of all households recorded health expenditures in a separate diary according to predefined categories that separated gratitude payments, private health services and medical products. Consequently the 1983 HBS provides a more reliable estimate of the share of informal payments; in that year households spent almost twice as much on gratitude payments than on private health services. For 1992 this ratio had seemingly been reversed, and in 1993 spending in the two categories was almost equal. While the collapse of the communist regime has created an opportunity for the expansion of the private sector, which would explain a shift between these two categories, change on such a scale is unlikely to have occurred, since, as we have discussed in chapter 2, the private sector is still very limited

in Hungary. But even if we assume that these findings represented reality, how could the subsequent year's change in the opposite direction be explained?

Table 6.6. Informal payments ('gratitude payment') and out-of-pocket payments to private providers ('health service') in Hungary according to the household budget surveys

	1983	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Health expenditures at current prices (billion HUF)												
Gratitude payment	1.398	n/a	2.440	3.875	4.313	4.666	5.271	5.775	5.900	7.890	9.037	17.122
Health services	811	n/a	4.270	3.265	4.060	6.333	6.129	7.741	10.483	8.792	30.496	18.741
Total	2.209	6.130	6.710	7.140	8.373	10.999	11.400	13.516	16.423	16.683	39.533	35.863
Gratitude payment as % of total	63%		36%	54%	52%	42%	46%	43%	36%	47%	23%	48%
Health expenditures at constant prices (1983=100)*												
Gratitude payment	100	0	45	59	55	47	43	39	35	43	45	78
Health services	100	0	137	86	90	109	85	91	108	82	260	146
Total	100	89	79	69	68	70	58	58	62	57	124	103
Health expenditures as % of previous year												
Gratitude payment				30%	-6%	-16%	-9%	-7%	-11%	22%	4%	73%
Health services				-38%	5%	22%	-22%	7%	18%	-24%	216%	-44%
Total			-11%	-13%	-1%	3%	-16%	0%	6%	-8%	116%	-17%

Notes: *Applying Consumer Price Index deflator

Source: Calculated from HCSO's HBS [259-261; 253; 76; 254-257; 27; 262; 263]

Findings of other surveys, which addressed not just informal payments but also out-of-pocket payments to private providers, seem to reinforce the explanation of discrepancies as misclassification (Table 6.7). While there is an almost two-fold difference between estimates of informal payment, overall expenditures in the SZGTI-1994 study are close to the HBS total for 1994. This suggests that informal payments are under-, while out-of-pocket payments for services are over-estimated by the HBS, especially given that the SZGTI-1994 estimate for the overall magnitude of informal payment is almost certainly an underestimate, given the exclusion of certain types of health care utilisation (such as those unrelated to specific episodes of illness). The 1997 'hidden economy' study of the HCSO also offers an example of misclassification, but the other way round. Its estimate of the overall magnitude of informal payments is almost half of the estimate yielded by the HBS for the same year, while out-of-pocket payments to private providers in the KSH-1997 study are almost three times as much as that of the HBS. The source of misclassification can easily be identified in this case, as some informal payments have been misclassified as formal out-of-pocket payments for health services, for which the provider did not issue an invoice or receipt. There is indirect evidence that respondents probably did not distinguish between gratitude payments and non-documented private payments to doctors. While the survey found

that 44% of all episodes of dental care were documented, the corresponding figure was only 19% for physician services, the lowest among all other services considered [225,p.8].

Table 6.7.

Overall magnitude of informal payments and out-of-pocket payments to private providers in Hungary according to three surveys

	SZGTI, 1994	KSH, 1997	Kecskemét study, 2001
Health expenditures at current prices (billion HUF)			
Gratitude payment	7.407	3.028	13.033
Health services	2.259	21.825	31.696
Total	9.666	24.853	44.730

Source: [75; 225, and own survey]

In general, if we compare total expenditures, including gratitude payments and health services, HBS estimates are closer to findings of other surveys (Tables 6.2,6.6,6.7). Nevertheless, HBS estimates of the overall magnitude of informal payments are still lower, which cannot simply be explained by misclassification of expenditure items. There is another methodological explanation for underestimation, which is associated with the limited ability of diaries to capture large but infrequent expenditures [27; 263]. Until 2000, household health expenditures had only been collected using diaries, but in 2000 data were also obtained from the annual interview, which, as in the other surveys considered here, is based on retrospective accounts of households. This methodological change offers a plausible explanation for the sudden increase of total expenditures in 2000, but also for the seemingly suspicious change in the share of informal payments between 2000 and 2001.

6.2.3.3. Health expenditures as rare events

The rationale for including the annual interview in the HBS is to provide a more reliable estimate of irregular or rare expenditures, usually on expensive items, such as cars, mobile phones, personal computers or washing machines. Experiences have indeed shown that households report expenditures on most of these items 4-11 times more frequently in the annual interview than in the one-month diary keeping period [262,pp.223-224; 263,pp.245-246].

Clearly some health expenditures, including informal payments for services such as complex surgical procedures are irregular and rare and, as we have shown, many would not have been captured prior to the inclusion of the annual interview in 2000, which is likely to have led to the underestimation of the overall magnitude of informal payments.

For instance, in 2000 there were 6,343 major heart operations in Hungary, equivalent to one procedure for every 1,600 inhabitants. If we assume, on the basis of the findings of the TÁRKI-1998 study, that about 60% of the patients pay the surgeon informally, and they pay an average of 50,000 HUF [214,pp.14,26], failure to capture payments for cardiac operations alone would result in underestimation of informal payments by about 200 million HUF.

The inclusion of household health expenses in the annual interview can thus be seen as an explanation for the more than doubling of total expenditures between 1999 and 2000 in real terms (Table 6.6). Nevertheless, this increase fell almost exclusively on out-of-pocket-payments to private providers ('health services'), because in 2000 the annual questionnaire did not distinguish between formal and informal payments [266,p.3], and the resulting excess amount was probably (mis)categorised as 'health services' and not 'gratitude payment'. In 2001, however, a more detailed questionnaire was introduced, which collected information on formal and informal payments separately according to the type of service [267,p.14]. This more accurate classification revealed the scale of underestimation and provided evidence that the one-month diary keeping period for one-twelfth of the household sample was insufficient to detect all episodes of informal payment. Between 2000 and 2001 the proportion of households, who gave informal payment 'increased' from 4.4% to 25% and the overall magnitude of informal payments almost doubled (Tables 6.6,6.8).

Table 6.8. Extent and magnitude of informal payment ('gratitude payment') and out-of-pocket payments to private providers ('health services') according to the household budget surveys

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Proportion of households, which had expenses on:										
Gratitude payment		5.7%*			5.2%*	5.1%*			4.4%**	25%***
Health services									29.3%**	26.6%****
Average amount in HUF per household, which had expenses on:										
Gratitude payment									55,719**	18,246***
Health services									27,780**	18,752****

Source: *[225]; **[27]; ***[265]; ****[263]

Underestimation resulting from misclassification and the unreliable detection of rare events can thus explain the discrepancy between findings of HBS and all but one of the other surveys presented in Table 6.2. The difference is still considerable between the 33

billion HUF of the TÁRKI-1998 study and an adjusted overall magnitude of 10-15 billion of the HBS for 1998, which merits further attention.

6.2.3.4. Recall bias

The differences between the research methods used in the TÁRKI-1998 study and the HBS can be used to explain this additional discrepancy, but if we take into account the adjustments described above, it is not possible to tell whether the HBS underestimates, or the TÁRKI-1998 study overestimates the overall magnitude of informal payments. First, although there is no reason to believe that respondent bias has had a different effect in the two studies, the HBS study could have suffered a more serious selection bias, insofar as the willingness of high income households to participate in a short, 30-minute interview is higher than in a demanding month diary exercise, and those who refused to undertake this task were thus excluded from the annual interview.

Second, in the TÁRKI-1998 study, Bognár et al. [214] collected data from about 1300 individuals, not households, which suggests that recall bias might have been less of a problem there than in the HBS. In other household surveys a single respondent had to provide information on other household members and it is not unreasonable to assume that individuals report their own experiences more accurately than those of others. On the other hand, there could be misunderstanding of the question with individuals reporting expenditures of the whole household, causing overestimation of informal payments. This possibility has been raised by the researchers in the TÁRKI-1998 study, but they argued that *“this misunderstanding did not happen at all, or only in exceptional cases”* [214,p.29]. On what basis they stated this is not clear.

To minimise underestimation from recall bias, interviewers of the TÁRKI-1998 study asked *“memory refreshing”* questions before they alluded to the actual amount of informal payments. According to Bognár et al. [214,p.28] this design increased the accuracy of responses. However, general questions on informal payments, such as ‘what proportion of patients pay?’, or ‘how much is the usual amount for ‘x’ service?’ might have created an atmosphere in which respondents felt pressure to overstate the payment if the amount they actually paid was lower than what they believed was typical.

Third, as Bognár et al. [214,p.28-29] acknowledge, the sample size was too small to detect rare events (such as the aforementioned cardiac operations) with confidence, which was not a problem in the case of the HBS annual interview. We should not forget that the unreliable detection of rare events could have caused not just under-, but

overestimation of informal payment, for instance if the 1,300 person sample included by chance two or three cases of cardiac operations, whereas their prevalence was only one per 2,000 person in 1998 [268,p.198].

6.2.4. CONCLUSIONS: AN ESTIMATE FOR 2001

To assess the overall magnitude of informal payments in Hungary we have placed the HCSO HBS under scrutiny. Comparing the estimates of the HBS with findings from other expenditure surveys and analysing the recent changes in the methodology of the HBS, we can conclude that during the 1990s, the HBS underestimated the overall magnitude of informal payments for at least two reasons. First, diary records did not provide a sound basis for the differentiation of informal and formal payments, and a substantial part of informal ('gratitude') payments was probably misclassified as out-of-pocket payments to private providers ('health services'). Second, the system of diary keeping was not a reliable means to detect informal payments for rare events, such as heart surgery or organ transplantation.

The incorporation of health expenditures and within that 'gratitude payments' into the annual interview of the HBS in 2001 has made visible the scale of underestimation, as expenditures on gratitude payment almost doubled between 2000 and 2001. While this methodological change brought HBS estimates closer to the findings of other surveys, the HBS estimate for 2001 is still significantly lower than the estimate of Bognár et al. for 1998 from the TÁRKI study, the only national representative survey dedicated entirely to informal payments during the 1990s.⁴³ It is not possible to tell whether the former underestimated or the latter overestimated the overall magnitude of informal payments, as there are arguments supporting both possibilities.

The most important problem with the HBS, which might have been a source of substantial underestimation, is the large number of refusals to keep a diary. Although the HCSO has implemented measures to increase response rates, in 2001 almost 3 out of 10 households still refused to participate in the survey (Table 6.3).

Let us assume that among non-participating households both the frequency of giving and the amount given were higher than among respondent households. Assuming that twice as many households paid on average twice the average amount, the HBS would have failed to capture 13.7 billion HUF (calculated on the basis of Table 6.8). Further, assuming that respondent bias among those who participated in the survey had also

distorted the overall magnitude of informal payment, with the highest figure of 20% of households concealing this kind of expenses at the average amount responding households paid (Tables 6.5,6.8), another 19 billion HUF would have been missed. In this scenario, the overall magnitude of informal payments would still remain at just under 50 billion HUF ($17.2+13.7+19=49.9$ billion HUF). Further, assuming that the HBS provided the lowest possible estimate, 16.2 billion HUF (with 95%CI), the overall magnitude of informal payments most probably fell between 16.2 and 49.9 billion HUF in 2001. Is this large enough to bother about?

According to the forthcoming estimate of the NHA, in 2001, public expenditures on health were 754.4 billion HUF, while private expenditures, excluding the NHA estimate of informal payment, were 295.3 billion HUF [269]. Thus, the 16.2-49.9 billion HUF in informal payments amounted to 1.5-4.5% of total health expenditures in 2001. Looked at this way, informal payments do not seem to be an important source of health care financing, especially in comparison with countries, such as Azerbaijan and the Russian Federation, where, according to Lewis more than half of total health expenditures are informal (84% and 56%, respectively), and even Poland, where the corresponding figure is 30% [96,p.19].

Nevertheless, even this relatively small amount can make a difference if informal payments make up a substantial part of the income of health workers, especially physicians, who make important resource allocation and distribution decisions in health care. As discussed previously, there is fairly conclusive evidence that informal payments are unequally distributed among health workers. Next, we will address this issue by calculating a likely distribution of informal payments among groups of physicians on the basis of available evidence to explore what informal payments may mean in terms of physicians' income.

6.3. The distribution of informal payments among physicians

The model which we use to show the implications of unequal distribution of informal payments among health workers has been built on three distributional dimensions: type of health worker (physicians vs. other health workers), levels of care (primary care vs. specialist care), and specialties (diagnostic and other supportive medical specialties vs. 'curative' specialties). We have assigned distributional weights to these groups of

⁴³ Significance is calculated using 95%CI from Bognár [214,p.29] and from Hungarian Central Statistical Office [263,p.252] using SE for all health expenditures.

health workers, on the basis of evidence reviewed in chapter 4, the secondary analysis of previous surveys and the findings of our own study. In the calculation we have worked with our lower estimate of the overall magnitude of informal payments for 2001 described before, first dividing the amounts between the various groups defined, according to the distributional weights, and then the number of physicians, to arrive at an average income that specialists and family doctors can be assumed to receive from informal payments. Data on the number of physicians are from the official statistics of the HCSO, which has its own data collection project covering the health workforce, but also reports tabulations of registered physicians in Hungary from the Hungarian Medical Chamber.

6.3.1. THE DISTRIBUTION OF INFORMAL PAYMENTS ALONG THREE DIMENSIONS

In Tables 4.4, 4.5 and 4.6 we have summarised the available evidence on the distribution of informal payments between physicians and other health care workers, between primary care and specialist care (including inpatient and outpatient care), and according to the type of services. As Table 6.9 shows, further evidence from the secondary analysis of previous studies (OTKI-1984 and TK-1985), as well as the findings of our own survey in Kecskemét supports the conclusion that physicians receive the majority, i.e. about 90% of informal payments.

Table 6.9. Distribution of informal payments between physicians and other health care workers

Year Study	Magnitude (HUF/respondent or utiliser)		Physicians' share (%)	Source Remarks
	Physicians	Other health workers		
1972/73, OTKI hospital	197	31	87%	[78] excluding non-respondents only money
1984, OTKI hospital	325	81	80%	[201] only paediatric hospitals
1985, TK hospital	1832	484	79%	[79]
outpatient specialist care	862	105	89%	
primary care	509	34	94%	
1997, KSH	737	46	94%	[225]
1998, TÁRKI hospital	6122	756	89%	[214,p.30]
outpatient specialist care	477	54	90%	
primary care	218	29	88%	
2001, KECSKEMÉT study	3337	259	93%	excluding non-respondents

As far as the levels of care are concerned, family physicians (primary care) receive about 30% of the money, according to the findings of the TÁRKI-1998 study. Although a much older study (OTKI-1969) came up with a similar figure (Table 4.5), the finding of our own survey shows only a 10% share for primary care. In the model, we take the estimate from the TÁRKI-1998, study as, in contrast with the other two, it was a nationally representative survey. However a sensitivity analysis using the lower estimate did not change the final conclusions.

Finally, we have further evidence from our own survey to support the observation that physicians in diagnostic and other support specialties receive no, or negligible informal payments. In the Kecskemét study we encountered no cases of informal payment for diagnostic services, which corresponds with the findings of the TK-1985 and TÁRKI-1998 studies, which asked about the opinion of the general population on this issue [79; 214].

6.3.2. THE NUMBER OF PHYSICIANS IN HUNGARY

The HCSO publishes data on the number of physicians from two sources within the framework of the so-called National Statistical Data Collection Programme (OSAP) [270]. First, in each year since 2000, the Hungarian Medical Chamber prepares a report on all the physicians in Hungary on the basis of a register it maintains (OSAP 1589,1590). Second, there is an obligation on all health care providers, whether public or private, to report on the establishment and employment of health care workers in their organisation (OSAP 1019). Comparison of the two data sources allows us to determine an approximate number of physicians in the aforementioned groups as the database of the Hungarian Medical Chamber includes all registered physicians, while the annual report of health care providers includes only those physicians, who are directly or indirectly involved in patient care.

Table 6.10 presents a breakdown of the number of physicians according to these two sources. The number of registered and of working medical doctors come from the register of the Hungarian Medical Chamber, while the number of physicians working in health care provider organisations comes from the providers' report. The difference is accounted for physicians, who work, for instance, for pharmaceutical companies, or for administrative bodies, such as the MOH or the NHIFA, or who are unemployed.

We have divided physicians working in patient care into three main groups: physicians in primary care (family doctors), specialists who usually do not receive informal payments and other specialists, who are assumed to receive informal

payments. ‘Non-paying’ medical specialties comprise three sub-groups. First, physicians in the National Public Health and Medical Officer Services, in the National Blood Supply Service and university researchers and teachers in non-clinical subjects (such as anatomy, physiology, biochemistry) who do not work in specialist in- or outpatient care. Second, there are a number of physicians, who work exclusively in the private sector, the most important group being dentists. Nevertheless, we have included all dentists, as dental care is part of publicly funded services. Third, there are physicians who work in- and outpatient care, but provide ancillary services, where direct patient-physicians encounters are limited. We have assumed that with the exception of these groups, all other physicians, including family doctors, may receive some informal payments.

Table 6.10. Number of physicians in Hungary, 2001

Physicians	Number		Remarks
Registered	39,648		Hungarian Medical Chamber, registration database
Active	33,088		
Working in patient care	30,586		Health care providers' report
1. Family doctor (primary care)	6,733		
2. Specialists in ‘non-paying’ specialties, of which:	7,740		
Public health		608	
Blood supply		163	
Education and research		1,306	
Dentists		2,763	number of entrepreneur dentists
Anaesthesiology		1,024	
Clinical laboratory		458	
X-ray and other diagnostic imaging		1,113	including diagnostic ultrasound
Pathology		305	
3. Specialists in ‘paying’ specialties	16,113		

Source: [271,17.1,17.5,17.9]

6.3.3. SYNTHETISING THE DATA: INCOME FROM INFORMAL PAYMENTS

We have created the model using the findings concerning the distribution of informal payments, the data on the number of physicians in the two, ‘paying’ groups and our upper and lower estimates for the overall magnitude of informal payments and present our findings in Table 6.11.

This indicates that both family doctors and specialists working in ‘paying’ medical specialties realized on average an income of about 50-160 thousand HUF⁴⁴ monthly from informal payments in 2001. At the same time, the official regular monthly gross salary of a family doctor was 77,156 HUF on average, while a specialist earned 102,819 HUF per month. If we add other earnings, the monthly gross salary totalled 120,666 and 148,348 HUF respectively [271,19.7].

Table 6.11. Estimated income of physicians from informal payments, 2001

	Share	Overall magnitude of informal payment (billion HUF)	Number of Physicians	Informal payment per physician (HUF)	
				/year	/month
Total (lower estimate)	100%	16.200			
Physicians total of which:	90%	14.580			
Family doctors (primary care)	30%	4.374	6,733	649,636	54,136
Specialists	70%	10.206	16,133	633,402	52,783
Total (upper estimate)	100%	49.900			
Physicians total of which	90%	44.910			
Family doctors (primary care)	30%	13.473	6,733	2,001,040	166,753
Specialists	70%	31.437	16,133	1,951,033	162,586

6.4. Conclusions: a relatively small overall amount can make a difference

So, how can we interpret the final figures from the model in terms of the importance of informal payments as an incentive for physicians?

To make an accurate comparison we assume that, except for a minor fraction of the overall amount, informal payments are not declared in tax returns and consequently are net income. Compared to the about 72,000 HUF net monthly salary for primary care physicians and the about 87,500 HUF for specialists, even the lower estimate of 53-54,000 HUF informal payments are considerable, at about 75% and 60% of their total net official salary respectively. Thus, for physicians, income from informal payment does matter, suggesting that informal payment is of a scale that does have relevance for health policy, not primarily because of its overall magnitude but of its unequal distribution among health workers.

⁴⁴ About €200-640.

While our analysis employed a crude distribution of informal payments among large groups of health workers, each physician in a particular group is most unlikely to receive the same amount of informal payments. There are other important differences between physicians that will influence distribution within these groups, such as the specialty, the type of health care provider, geographical location and the physicians' position in the hierarchy. For instance there is evidence that obstetrics-gynaecology and surgery are better 'paid' medical specialties than internal medicine or psychiatry [79; 201; 214]. Unfortunately the missing data of the OTKI-1984 study made it impossible to quantify these differences. While we could not refine our model by incorporating these further dimensions, they would have certainly amplified the differences by increasingly concentrating informal payments in the hands of a smaller and smaller group of physicians. For some, the unequal distribution of informal payments will make a very big difference.

CHAPTER 7. MOTIVATION AND EQUITY

7. IMPACT OF INFORMAL PAYMENTS ON EQUITY

Having established in chapter 6 that informal payment is important in terms of its scale, the next step in establishing its policy importance is to examine the motivation of the participants in the transaction. As we have argued before, the key issue is whether informal payments are ‘donations’ motivated by gratitude, or ‘fee for service’ motivated by the desire to receive better care. In the next three chapters we contrast these two hypotheses by using the concept of, what we call, the ‘coercion factor’. Given that the key distinctive feature of gratitude payments is that they are paid voluntarily, the validity of the ‘donation’ hypothesis would be questioned if one could detect any kind of direct or indirect pressures on patients to pay.

Using the contrasting assumptions of the ‘fee-for-service’ and the ‘donation’ hypotheses, we attempt to capture this ‘coercion factor’ by presenting empirical evidence relating to the two main research areas described in Table 5.1. One of them, the equity impact of informal payments, addressed in this chapter is indirectly related to the ‘coercion factor’,⁴⁵ while we directly address the motivation of participants in chapter 8 by examining the possible discrepancies between what survey respondents stated motivated them to pay providers informally and the broader context in which the transaction occurred.

7.1. Equity and the motivation of informal payments

On the basis of the ‘donation’ hypothesis we have assumed that if informal payments are really given voluntarily, those patients who cannot afford to pay, simply do not pay. That is informal payments neither represent a barrier to accessing services, nor people are willing to shoulder a disproportionate financial burden (compared to their ability to pay) to give informal payments. However, if informal payment is associated with coercion, in any form, it makes it the worst possible form of private financing since those already vulnerable will be least able to resist and its informal nature makes it difficult to tackle abuses. In this chapter, we present our findings from the Kecskemét study and complement them with the analysis of official statistics and secondary analysis of other surveys within this explanatory framework.

⁴⁵ It must be noted that the impact of informal payments on equity is directly related to the policy importance of informal payments. Because we selected the motivation issue as the organising theme of (→)

Although we have briefly touched upon the concept of equity in chapter 1, in the following sections we provide a more detailed discussion of how equity has been conceptualised and measured within the framework of this study, before presenting our findings.

7.1.1. CONCEPTUALISATION OF EQUITY

Equity is a concept of distributive justice [e.g.62; 60,pp.15-31,54-60; 53,pp.36-38; 272], in which the members (individuals or groups) in a society decide how to distribute something that they care about. As we have discussed in chapter 1, equity is one of the performance criteria used to assess health care systems. An emphasis on equity focuses on the distribution of something in contrast to maximisation of its overall level (aggregate) given available resources (the criterion of efficiency).

In economics the distribution of goods and services (and hence the distribution of income, which is the means of obtaining goods and services) is considered. The various goods and services, which include health care, have costs and benefits, whose distribution can be studied separately, and referred to as 'incidence' [60,pp.54-60]. The distribution of the cost burden in obtaining goods and services is referred to as fiscal incidence and the distribution of the benefits of goods and services, derived from their consumption (utilisation) is referred to as expenditure (or benefit) incidence.⁴⁶

Incidence is a positive concept insofar as it describes any distribution without taking a stance on the fairness (justice) or unfairness (injustice) of a particular distribution. While the concept of equity also involves analysis of the distribution of the cost burden of goods and services, which is referred to as equity in financing, and the distribution of the benefits of consumed goods and services, which is referred to as equity in benefits (or service delivery), it goes further by evaluating the fairness of this distribution [273]. But, as we have pointed out in chapter 1, what is fair or unfair, depends on one's moral-philosophical standpoint, i.e. on one's view of 'the good society'. Different moral-philosophies imply different concepts of fairness, so different people may think

our study, for the ease of presentation we have decided to relate the equity issue to the two contrasting hypotheses of the motivation of participants, and not to the policy importance of the phenomenon.

⁴⁶ They also talk about net (or budget) incidence, when fiscal and expenditure incidence is added up, and tells us whether any particular individual or group of people is better or worse off as a result of a particular program. Economists also distinguish statutory and economic incidence as those who should bear the cost burden of any program according to the provisions of laws and regulations are often not those, who eventually pay, since private actors are often capable to shift this cost burden to others directly or indirectly. [60,pp.54-60]

different distributions of health care equitable or inequitable. Thus, equity is a normative concept, which involves value judgements.

Although the various philosophical positions provide a valuable conceptual framework to contrast the essence of different concepts of justice, they are of limited use to policy-makers for two reasons. First, as we have discussed in chapter 1, policy makers and the public that they represent are not exclusively committed to one particular moral-philosophy. Second, and more importantly, it is not always straightforward to translate the various principles into the language of practice. For instance, it does matter whether we would like to provide a minimum level of health for everybody or whether we would like to minimise the difference between those with the lowest level of health and those with that of the highest. There could even be different interpretations of what that minimum level of health means, and whether it is more desirable to bring as many as possible closer to this line or only the number of people, who go beyond the line is important. It also makes a difference whether we consider the ultimate health status of the members of the society, or only the distribution of utilisation of health services or even the opportunity for utilisation (access).

A somewhat more useful way to put the various moral-philosophies into practice is to distil the contrasting concepts of justice into intermediate concepts, which can independently be applied to different aspects (elements) of health care. In the case of equity in health care financing these are the ‘ability to pay’ versus the ‘benefit’ principle, whereby the former requires that the cost burden of health care to be borne according to one’s ability to pay as opposed to the latter, which considers it fair if those who benefit from health care pay for the services they utilise [273]. In the case of equity in health care delivery, these are the distribution of (the benefits of) health services according to ‘needs’ versus ‘willingness (and ability) to pay’, whereby needs are defined as capacity to benefit from the receipt of health services [274; 275; cited in 273,p.1813], and willingness to pay is linked to one’s capacity to pay for health services and the right to choose how to spend one’s income, which is also referred to as a distribution based on ‘merits’ [273,p.1809], or as Miller [276; cited in 59,p.53] puts it “*deserts*”.⁴⁷ While these intermediate concepts bring the abstract principles closer to practice, and the benefit principle coupled with a merit-based distribution of health

⁴⁷ The merit or desert based distribution is linked to ability to pay, and sometimes referred to as distribution according to ability to pay [e.g.277; in 273,p.1809], but I prefer to use the first two terms, as the latter can easily be confused with the ‘ability to pay’ principle in equity in financing, but the two describe two incompatible principles in equity in service delivery and financing.

services provide a relatively straightforward guide for implementation (where policy-makers adopt a libertarian position), the ‘ability to pay’ principle and the principle of distribution of health services according to ‘need’ are still ambiguous concepts. The ‘ability to pay’ principle does not tell us exactly how much people with different incomes should contribute to the financing of health care and the receipt of services is influenced by factors other than need [278; cited in 273,p.1813]. Further, although it makes sense in the measurement of equity, the separation of financing and service delivery is somewhat artificial insofar as the system of financing can be a barrier to accessing health care. All these points are very well illustrated in relation to the health policy objective of ‘equal access for equal needs’, which, as we have discussed in chapter 1 (Box 1.1) the Hungarian health care system seeks to achieve.

7.1.2. INTERPRETATION AND MEASUREMENT OF ‘EQUAL ACCESS FOR EQUAL NEEDS’

Wagstaff and van Doorslaer [273,p.1812] argue that policy-makers and academics alike often equate ‘access’ with the ‘receipt of treatment’, although, as LeGrand [279] and Mooney [278] point out, the two are not the same, since the former represents only the opportunity to use health services and not the actual utilisation of health care. LeGrand [279; cited in 273,p.1812] has proposed conceptualising ‘access’ in terms of the money and time costs incurred by patients to obtain care, and the principle of ‘equal access for equal needs’ thus would require that patients with equal needs face the same cost of obtaining care. While LeGrand rightly reminds us not to confuse access with utilisation, this definition of access to care does not take into account how the same costs of obtaining care require a greater sacrifice by a poor than a rich patient [e.g.280; cited in 273,p.1812]. Indeed, the principle of ‘equal access for equal needs’ implies that access to care should depend on ‘need’ rather than ‘merit’ (i.e. willingness to pay), and even where patients with the same needs face the same costs, this could still deter the poor from utilising health services insofar as these costs represent a greater part of their smaller income. Further, as Culyer [281; cited in 273,p.1817] noted, the justification of the ‘ability to pay’ principle in financing health care is to promote equity in the delivery of health care. Charging the same co-payment, or even the full cost of services for patients with the same health need would satisfy LeGrand’s condition of equal access, yet it is contrary to the ability to pay principle. It does not ensure that those who cannot afford to pay for services out-of-pocket will be able to use services if they are needed,

consequently it is not consistent with the spirit of distribution of health services according to needs.

Notwithstanding that ignoring the ‘ability to pay’ principle in equity in financing goes against a need-based distribution of health care, Wagstaff and van Doorslaer [273,p.1817] argue that justification of the ‘ability to pay principle’ on the basis of equity in service delivery requires only that payments be separated from utilisation, and not that the poor pay an equal or smaller share of their income than the rich (proportional or progressive financing). They argue that, for example, “*decoupling*” payments from utilisation with the introduction of a lump-sum tax would eliminate the direct deterrence effect of user-charges, thereby would ensure equal access to health care, yet would require the poor to pay a larger share of their income than the rich (regressive financing). They conclude that the justification of the ‘ability to pay principle’ has to come from elsewhere, for instance to protect patients from health care payments that would preclude their consumption of essential goods and services [281; cited in 273,p.1817]. Although they contend that such a proposition would support contributions according to ability to pay further than simple “*decoupling*”, I argue that Culyer’s argument has a special relevance to both the ‘ability to pay’ and the ‘equal access for equal needs’ principles. First, where many people are only just able to afford basic necessities, such as food and clothes, one cannot exclude the possibility that their consumption of these items will be adversely affected by a regressive lump-sum tax for health care. Second, if we accept that the rationale of the ‘ability to pay’ principle is indeed the desire to protect the individual’s expenditures on other essential goods and services, then user-charges per se are not problematic, but only if they are not tailored to the ability of individual patients to pay, i.e. they represent a disproportionate burden on patients or households.

We have measured the equity impact of informal payments in this sense on both the financing and the delivery sides. Although informal payments, as direct payments, are by definition regressive (there is no transfer between the sick and the healthy), the link between payments and utilisation does not in itself question the validity of the ‘donation’ hypothesis. We have hypothesized that payments that are at least proportionate to the income of those who utilise health care are not incompatible with the ‘donation’ hypothesis in that they could really be given voluntarily, with the provision that the amount paid does not exceed disposable income. However, if the poor pay a larger share of their income than the rich, especially where they must mobilise resources other than their disposable income (from savings, borrowing, etc.),

this would contradict the gratitude payment hypothesis. We have examined these possibilities using official statistics (the HBS of HCSO), the secondary analysis of the OTKI-1984 and TK-1985 studies, and our Kecskemét study, which included a question on the sources of money used to pay for health care.

In accordance with the ‘equal access’ principle, we have assessed equity in service delivery in two particular areas. Previous surveys and official statistics did not contain data that would have enabled us to analyse the direct deterrence effect of informal payments, i.e. whether or not they prevented utilisation of health services. We have addressed this issue in our Kecskemét study, by finding out how many people did not utilise health care or delayed utilisation for financial reasons, and by finding out whether money was a significant factor in failure to complete treatment. Of course, any direct deterrence effect would contradict the ‘donation’ hypothesis. Second, we have looked for evidence of differentiated treatment between ‘paying’ and ‘non-paying’ patients. Although this relates to service utilisation and not access per se, any difference implies different opportunities, even if access is not totally denied.

7.2. Informal payments and equity in financing

In the statistical publications of the HCSO on the HBS there are data on household income and expenditures by income decile. In 2000, this breakdown was changed to income quintiles, but while retaining income and expenditure data for the first and the tenth income deciles [27,pp.64-65; 262,pp.26-27; 263]. These data enable us to calculate the share that average per capita expenditure on gratuities constitutes in average per capita income in each income quintiles (deciles). Table 7.1 shows this calculation.

As we can see, average per capita gratitude payments in absolute terms are increasing across the income spectrum. In 2001 average per capita spending on gratuities was 2.5 times higher in the highest income decile than in the lowest. Although the pattern of gratuities as percentage of income is not consistent across the range, the comparison of the first with the tenth income deciles and the first with the fifth income quintiles show that these amounts represent a larger share of the income of the poor than the rich. This association is more marked if we consider only disposable income. First, we have subtracted from the average per capita income only food consumption, which has not just increased the differences, but made the pattern of decreasing proportion of gratuities with income quintiles (deciles) unequivocal. Second, if we consider the national poverty line, which is set by the HCSO each year,

we can see that the smallest per capita amount (the poverty line for a family of two adults and four children) is higher than not just the first income decile, but the first income quintile as well. This suggests that households in the poorest 20% of the population pay informal payments despite being under the national poverty line, which contradicts the ‘donation’ hypothesis of informal payments.

Table 7.1. Informal payments and equity in financing health services in Hungary: household budget survey for 2001

	First income decile	Income quintiles					Tenth income decile
		1 st	2 nd	3 rd	4 th	5 th	
Per capita expenditure on gratuity (HUF/year)	839	887	1,210	1,953	2,077	2,384	2,137
Expenditures on gratuity per household (HUF/year)	3,071	3,140	3,678	5,000	4,902	5,388	4,744
Per capita net income (HUF/year)	194,771	241,173	365,914	455,138	565,011	904,304	1,098,657
Net income per household (HUF/year)	712,862	853,752	1,112,379	1,165,153	1,333,426	2,043,727	2,439,019
Gratuities as % of income	0.43%	0.37%	0.33%	0.43%	0.37%	0.26%	0.19%
National minimum food consumption per capita (HUF/year)	127,272* - 149,376**						
Per capita disposable income (net income minus food consumption)***	67,499	113,901	238,642	327,866	437,739	777,032	971,385
Gratuities as % of disposable income	1,24%	0,78%	0,51%	0,60%	0,47%	0,31%	0,22%
National poverty line per capita (HUF/year)	290,532* - 471,132**						

Notes: *Household with 2 adults and 4 children; **Single person; ***Using minimum per capita food consumption in households with 2 adults and 4 children;

Source: HCSO, partly own calculations [263; 282]

Nevertheless, the limitation of these crude calculations is that they do not take into account the real incidence of informal payments. First, in a given year not all households have at least one member who utilised health services, and second, among those who used health services not all paid the physician informally. The average per capita informal payments shown in Table 7.1 reflect this point very well as they are only a small fraction of the average per capita income even in the poorest decile of the population, even if food consumption is deducted. Unfortunately, the HBS data do not allow us to make any such analysis, since there are no data published on health care utilisation according to income groups.

To go one step further, we have used the data of our Kecskemét study. Table 7.2 presents the findings of our analysis, in which we have calculated the frequency of giving among users as well as the average amount of informal payments among those households who paid, both according to income quintiles.

Table 7.2. Informal payments according to income quintiles: Kecskemét study, 2001

	Income quintiles				
	1 st	2 nd	3 rd	4 th	5 th
Number of households	145	144	145	144	145
Percentage of households with cases of health care utilisation of public providers (with 95%CI)	71.7% (64.2-79.2)	67.4% (59.5-75.2)	65.5% (57.6-73.4)	56.9% (48.7-65.2)	53.1% (44.8-61.4)
Number of households with cases of health care utilisation of public providers	104	97	95	82	77
Percentage of households with cases of informal payments to public providers (with 95%CI)	24.0% (15.7-32.4)	16.0% (8.7-23.3)	28.2% (17.2-39.2)	13.7% (5.2-22.2)	24.4% (14.9-33.9)
Number of households with cases of informal payments to public providers	25	16	19	9	20
Expenditure on gratuity per household in HUF/4 months (with 95%CI)	7,820 (4,650-10,990)	14,656 (2,246-27,067)	10,626 (4,806-16,447)	16,717 (0-37,476)	8,645 (5,331-11,959)
Median amount of informal payments (HUF)	5,000	5,000	5,000	2,000	7,750
Mode of informal payments (HUF)	5,000	1,000	10,000	1,000	1,500
Per capita expenditure on gratuities in HUF/4 months (with 95%CI)	2,080 (1,550-3,663)	4,343 (749-9,022)	3,365 (1,602-5,482)	5,572 (0-12,492)	3,529 (1,777-3,986)

Although the utilisation of public providers is higher among households in the poorer than the richer income quintiles, the percentage of households who made informal payments is almost the same in the first and the fifth income quintiles. Furthermore, there is hardly any difference between the average amount of informal payment per household in the poorest and the richest income quintiles even in absolute terms. This suggests that the burden of informal payments is not at all proportionate to the income of households and that among those who pay, informal payments are more like a ‘fee for service’ than a ‘donation’.

Nevertheless, the finding that there is no statistically significant difference between the average amounts of informal payments according to income quintiles has to be interpreted with caution. The 95% confidence intervals (CI) for these figures are strikingly wide for two reasons. First, of the small number of cases, especially in the second, third and fourth income quintiles, all of which involve less than 20 households, make the analysis of statistical significance meaningless. Unfortunately, we had to exclude from the analysis 91 households, where the respondents refused to provide information on household income and 3 cases of informal payments, where the respondent admitted giving informal payments, but refused to state the amount. Second, there was a large dispersion of values, which ranged between HUF 150 and 95,000 across income quintiles. This is attributable to the fact that our analysis included informal payments for all (and thus very diverse) services at all levels of care from

family doctors to hospitals. Although our research would in principle allow us to carry the analysis further by creating more homogenous groups of services, such as for inpatient care, the small number of cases has prevented a meaningful analysis. A further limitation is that the exclusion of households on which we did not have income data could have distorted the findings, insofar as higher income households were more likely to refuse to answer the income-related questions. Among the 91 households excluded, 54 utilised health care at public providers, and 4 gave informal payments.

To investigate the issue further, we have used data from two studies whose design makes it possible to overcome these shortcomings. Both the OTKI-1984 and the TK-1985 were implemented before the 1988 tax reform, when the personal income tax was introduced, and as Bondár and Ékes [75] argued, income data obtained from surveys were much more reliable during that period. Indeed, in the secondary analysis of the TK-1985 study, we had to exclude only one case because of missing income data, and no cases at all from the OTKI-1984 study. Further, the larger sample sizes, especially in the OTKI-1984 study, made it possible to disaggregate cases according to broad categories of services, from which we have selected hospital inpatient care, and within that, informal payments to physicians only. From the OTKI-1984 we have considered paediatric hospital cases as, for reasons that are unclear, the database contains informal payment data for only these cases.

Table 7.3 presents our findings from the TK-1985 study. Although the richest 20% of the population gave informal payments to hospital physicians significantly more frequently than the poorest 20%, the average amount of gratuity per payer shows no significant difference (using 95%CI) across income quintiles, with the exception of the second and fifth quintiles. This reinforces our previous finding that informal payments are closer to ‘fee for service’, and consequently represent a disproportionate burden on poorer households. Nevertheless, as shown in Table 7.3, the 95%CI for the average amount of informal payments are still rather wide, with values ranging from a few hundred HUF to over 10,000 in each income quintile. One plausible explanation is that hospital services are too heterogeneous, and it is necessary to try to specify the services received further. The OTKI-1984 study has provided us with this opportunity, as the database contains information on the causes of hospitalisation (observation, check-up, treatment with operation, treatment without operation, accident, other) and the sample size was large enough to obtain a sufficient number of cases even for more specific services identified this way.

Table 7.3. Informal payments to hospital physicians according to income quintiles: TK-1985 study

	Income quintiles				
	1 st	2 nd	3 rd	4 th	5 th
Number of individuals*	199	200	200	200	198
Percentage of individuals, who were treated in hospital (with 95%CI)	46.7% (39.7-53.8)	48.0% (40.9-55.1)	40.0% (33.1-46.9)	42.5% (35.5-49.5)	45.5% (38.4-52.5)
Number of individuals, who were treated in hospital	93	96	80	85	90
Percentage of individuals, who paid the hospital physician informally (with 95%CI)	29.0% (19.6-38.4)	33.3% (23.7-43.0)	40.0% (29.0-51.0)	45.9% (30.7-45.9)	50.0% (39.5-60.5)
Number of individuals, who paid the hospital physician informally	27	32	32	39	45
Average amount of gratuity per payer (with 95%CI)	1,686 (930-2,441)	1,366 (1,057-1,674)	1,914 (1,056-2,772)	2,336 (1,533-3,139)	2,407 (1,723-3,090)
Median amount of informal payments (HUF)	1,000	1,000	1,000	1,500	1,500
Mode of informal payments (HUF)	1,000	1,000	1,000	1,000	500

Note: *The sample consisted adults only, aged over 18.

Source: Secondary analysis of the TK-1985 study [79]

Table 7.4 presents the findings of the secondary analysis of the OTKI-1984 study. We have considered first informal payments to hospital paediatricians, and then we have narrowed down the analysis to cases of operations only. As we can see, the findings exhibit a pattern that is very similar to the findings of the TK-1985 study concerning the frequency of giving, both for paediatric inpatient care in general and surgical operations in particular. The average amount of informal payment, however, is not similar, but considerably higher among the poorer families than the richer ones, thereby undermining further the ‘donation’ hypothesis of informal payments. Unfortunately we could not verify the difference statistically, because the cases of the non-proportional stratified sample had to be adjusted (multiplied) during the analysis using weights, which provided extreme big, and thus unreal, sample size.⁴⁸ Results in the fifth quintile are the most problematic in this sense, because the number of real cases of informal payments could be somewhere between 20 and 40. Given that the amounts of informal payment vary considerably (they fell between HUF 100 and 10,000) the Standard Error (SE) must be high, which implies confidence intervals as wide as those we found in the other two studies discussed before. This equally applies to informal payments for operations, as the limitation of the analysis to surgical cases failed to restrict the variation of amounts as we expected, while reducing the number of

⁴⁸ The corrective weights were defined so that the final ‘sample size’ was the whole population of Hungary (10 million), i.e. one case in the sample represented 124 to 2569 ‘cases’ after the corrective weights were applied in the analysis. With this new (virtual) sample size, very minor differences were statistically significant (type I error).

cases further. While the existence of this variation even where services are more narrowly defined would fit better the ‘donation’ hypothesis, in itself it does not contravene the ‘fee-for-service’ explanation. Different operations can have different ‘fees’, and even the ‘fee’ for same type of operation can vary with different health care institutions and in the same health care institutions with different physicians.

Table 7.4.

Informal payments to hospital paediatricians and for paediatric operations according to income quintiles: OTKI-1984 study

	Income quintiles				
	1 st	2 nd	3 rd	4 th	5 th
Number of households*	757,220	761,627	758,988	755,931	763,291
Percentage of families with children	55.5%	46.5%	35.9%	23.4%	6.5%
Number of families with children*	420,058	354,065	272,213	176,731	49,461
Percentage of families with child treated in hospital (past three years prior to the survey)	55.7%	55.2%	55.3%	59.2%	53.7%
Number of hospital cases*	186,276	158,769	121,815	72,050	22,878
Percentage of families who paid the physician informally	38.1%	47.8%	49.3%	55.4%	74.7%
Average amount of informal payment per payer (HUF)	2,126	1,995	2,252	1,249	975
Median amount of informal payments (HUF)	700	1,000	500	500	500
Mode of informal payments (HUF)	500	500	500	500	500
Number of surgical cases*	82,085	71,124	63,509	46,104	16,782
Percentage of families who paid the surgeon informally	47.6%	54.4%	50.0%	58.1%	78.7%
Average amount of informal payment per payer (HUF)	2,097	2,048	2,097	1,262	685
Median amount of informal payments (HUF)	500	600	800	500	500
Mode of informal payments (HUF)	500	500	500	500	500

Note: *Cases are multiplied by weights to make the sample representative nationally. The sample includes only 7,398 households. Since weights had to be applied, the statistical significance of differences could not be calculated.

Source: Secondary analysis of the OTKI-1984 study [201]

Using the arithmetic mean as a measure of central tendency, however, is problematic where there may be distortion caused by one or two extreme values. Thus, in Tables 7.2, 7.3 and 7.4 we have included other measures of central tendency not sensitive to extreme values. As we can see, both the median and the mode also show that there is hardly any difference between income quintiles.

In conclusion, there is evidence from all the studies considered here that health expenditures on informal payments represent a disproportionate burden on poor households, but the finding that those who pay, pay on average about the same needs to be explored further. This analysis has used the average amount of informal payment and income in the five groups of income quintiles, and has assessed the cost burden

indirectly insofar as we have assumed that payments that represent a larger share of the income of the poor than the rich adversely affect the former’s consumption of other essential goods and services. A more direct indication of a disproportionate burden, and thus a more straightforward case against the donation explanation, would, however, be if households mobilised their reserves or relied on external resources to cover informal payments. We have attempted to assess exactly this aspect of equity in financing in our Kecskemét study, as the other surveys and official statistics do not contain any specific information in this respect.

7.2.1. HOUSEHOLDS’ SOURCES OF FINANCE TO COVER INFORMAL PAYMENTS

In the Kecskemét study, we asked respondents in households incurring out-of-pocket expenditures for health care utilisation about where the money came from (see Question 32 in Appendix D4). For each episode of care we wanted to know whether they had to use financial resources other than the household’s regular income. We have considered the use of savings, the sale of assets, borrowing or external help as a direct manifestation of inequity in financing and which is incompatible with the donation explanation of informal payments.

Table 7.5. The distribution of financial sources, that were used to cover out-of-pocket payments for health care, and within that informal payments: Kecskemét study, 2001*

	Cash revenue	Savings	Sale of assets	Donations	Loan	Other
Cases of health care utilisation						
Use of sources as % of cases of health care utilisation (N=626)**	89.9% (87.5-92.3)	7.3% (5.2-9.4)	0.2% (0-0.7)	2.2% (1.0-3.4)	0.2% (0-0.6%)	0.5% (0-1.1)
Percentage of cases, who relied on non-cash revenue**		9.1% (7.3-12.0)				
Use of sources as % of cases of informal payments (N=104)**	90.4% (88.0-92.4%)	14.4% (11.5-17.3)	1.0% (0.2-1.8)	4.8% (3.0-6.6)	0	1.0% (0.2-1.8)
Percentage of cases, who gave informal payments and relied on non-cash revenue**		19.2% (11.5-27.0)				
Households						
Percentage of households, who used non-cash revenues to cover informal payments (N=89)**		20.2% (11.7-28.7)				

Notes: *See Question 32 of the questionnaire in Appendix D4 (multiple answers were allowed); **With 95%CI in parenthesis

Table 7.5 summarises our findings for all episodes of care that involved in any type of out-of-pocket payments and for episodes where informal payments were given. As we can see, informal payments required these alternative sources of funds in 19% of the 104 cases. At the level of households this means that a little more than 20% of them

had at least one episode of care in which informal payments were covered from exceptional sources, mainly from savings and external help (donations). This finding suggests that informal payment does represent a special financial burden for at least one in five households, and it cast doubt on the validity of gratitude being the only motivating factor, since a sizable proportion of households do make informal payments, even if they have to sacrifice savings or household assets.

Nevertheless, this figure of 20% does not mean that for the other 80% of the households informal payments are an insignificant issue. It is possible that a household paid for informal payments only from general income, because it had no savings or valuable assets to sell, and informal payment impacts immediately on spending on other essential goods and services, precisely because the special financing options considered above were not available. Our study was not designed to address this issue in detail, but it is certainly an interesting topic to be explored by future research.

So far, we have considered the financial burden that informal payments represent when paid when health care is utilised. An equally important aspect of the equity impact of informal payments though, whether perceived pressure to pay can prevent the utilisation of health care in the first place. Consideration of this potential deterrence effect of informal payments leads us from financing to service delivery.

7.3. Informal payments and equity in health care delivery

In the Kecskemét study, we tried to assess the barrier created by the need for money to access health services, by finding out how many people did not utilize or delayed utilization of health care for financial reasons (see Questions 11, 14 in Appendix D4). Further, we tried to find out whether money was a significant factor in failure to complete treatment (see Question 19 in Appendix D4). Finally, in line with the broader interpretation of access to care, we also undertook secondary analysis of available databases to seek evidence of unequal treatment associated with informal payments.

7.3.1. SELF CARE AND DELAYED TREATMENT

The assessment of non-utilization and delayed treatment is very important in terms of the establishment of informal payment as a barrier to access to care. As we have discussed in chapter 2, there is virtually no formal co-payment for the utilization of publicly funded health services in the Hungarian health care system, so any self care or delayed treatment for financial reasons can be attributed primarily to informal payments (although noting also the potential impact of other costs such as transport).

Table 7.6. Reasons for self care: Kecskemét study, 2001*

	Frequency	Percent (with 95% CI)
Not serious*	27	75.0% (60.6-89.4)
Afraid, ashamed to go*	0	
Not enough money*	0	
Denied care*	0	
Required service was not available*	0	
Treatment is ineffective*	0	
Other*	8	25.0% (10.6-39.4)
Of which:		
Know how to treat**	3	
It was weekend**	1	
Just started**	2	

Notes: *See Question 11 in Appendix D4; Multiple answers were allowed; N=36; **Recoded from the category of 'Other';

Table 7.6 presents our findings concerning reasons for lay care. Altogether, we have identified 813 disease episodes in 531 households with at least one episode of illness during the 4 months in question prior to the survey. Among the 813 episodes of illness, we have identified only 36 cases of lay care (4.4% of all disease episodes) in 28 (or 5.3% of the) households. The analysis of answers to the question "If no formal treatment was sought, what were the reasons?" (see Question 11 in Appendix D4) has shown that there is no evidence to support the hypothesis of money being a barrier to access to care (Table 7.6). We have not found a single case in which an ill person did not utilise health care because she did not have enough money.

Table 7.7. Delayed health care utilisation: Kecskemét study, 2001

Q13. How long did the person wait before seeking care?*		Frequency	Percent	Valid Percent (with 95%CI)	Valid Percent of Acute Illness (with 95%CI)
Valid	Chronic illness	223	28.7%	30.5% (27.1-33.9)	
	Immediately	305	39.3%	41.7% (38.1-45.3)	60.0% (55.7-64.4)
	Few hours	37	4.8%	5.1% (3.5-6.7)	7.3% (5.0-9.6)
	Less than a week	102	13.1%	14.0% (11.4-16.6)	20.1% (16.5-23.6)
	More than a week	64	8.2%	8.8% (6.7-10.9)	12.6% (9.7-15.5)
	Acute illness total	508	65.4%	69.5% (66.1-72.9)	100.0%
	Total	731	94.1%	100.0%	
Missing		46	5.9%		
Total		777	100.0%		

Notes: *See Appendix D4 for the questionnaire

However the situation is not unequivocal if delayed treatment is looked at. In 40% of the 508 episodes of acute illness patients did not see the doctor as soon as symptoms appeared, with 12.6% waiting more than a week (Table 7.7). The reasons for delayed health care utilisation are shown in Table 7.8. Although money does appear, the

number of cases is very small: three. The finding that nobody was deterred from using health services and only a very few ill persons delayed utilisation for financial reasons suggests that financial barriers, which include informal payments, play only a very minor role in access to care, at least if the first contact with providers are considered.

Table 7.8. Reasons for delayed health care utilisation: Kecskemét study, 2001*

	Frequency	Percent (with 95%CI)
Not serious illness*	150	78.1% (72.1-84.1)
Afraid, ashamed to go*	5	2.6% (0.3-4.9)
Not enough money*	3	1.6% (0-3.4)
Health facility is far from us*	0	0
Treatment is ineffective*	0	0
Other*	46	24.0% (17.8-30.2)
Of which:		
No time**	5	2.6% (0.3-4.9)
Did not want to be absent from work**	3	1.6% (0-3.4)
It was weekend, end of month, bank holiday**	19	9.9% (5.6-14.2)
Did not know it was an illness**	3	1.6% (0-3.4)
Elective procedure**	4	2.1% (0-4.2)
Lazy**	2	1.0% (0-2.5)

Notes: *See Question 14 in Appendix D4; Multiple answers were allowed; N=192. **Recoded from the category of ‘Other’

Nonetheless, another interesting finding emerged from the analysis of ‘other reasons’ for delayed treatment. The far most frequent other reason was that it was weekend or bank holiday, comprising almost 10% of all causes. Here is a possible indirect link to financial reasons. Home visits by medical doctors are well known as eliciting informal payment and it is plausible that this may be a factor in some people not seeking care at the weekend. However it is not possible to confirm this hypothesis from the available data, since no further inquiry was made into why weekends were a barrier to access to care, and of course some people simply did not want to interrupt their weekend by seeking care if the disease was not considered to be serious.

7.3.2. UNCOMPLETED TREATMENT

Questions regarding uncompleted treatment further support the finding that money may influence access to care, but only to a limited extent (see Questions 17, 18, 19 in Appendix D4). The survey has identified only four cases of interrupted treatment, which does not permit any meaningful quantitative analysis (Table 7.9). Uncompleted treatment requires a more complex analysis, insofar as it does not necessary result from the inability to pay informal payment. For instance, substantial co-payment is required for pharmaceuticals. Hence, we had to analyze questions about ‘How was the treatment

interrupted?’ (Question 18) and ‘If treatment was interrupted, what were the reasons?’ (Question 19) together.

Table 7.9. Reasons for interrupted treatment: Kecskemét study, 2001

	Frequency
Not enough money*	1
Afraid, ashamed to go to specialist/hospital*	0
Required service was not available*	0
Treatment is ineffective*	1
Got better*	0
Other*	3

Notes: *See Question 19 in Appendix D4; Multiple answers were allowed; N=4.

There was one case of a spinal problem in which the patient did not buy the prescribed medicines because he did not have enough money. Thus the only identified case where treatment was not completed for financial reasons was not associated with informal payment but formal co-payment. The other three cases, (a) a spinal problem for which the patient sought alternative therapy, (b) a fracture with the patient being unsatisfied with the care provided, and (c) influenza where the patient could not be bothered to return to the doctor, do not suggest that out-of-pocket payments ‘during care’ acted as a barrier to access. It has to be noted, however, that these findings are related to acute care only. The interpretation of the concept of complete and incomplete treatment is not so straightforward in the case of chronic conditions. These ‘episodes’ are by definition incomplete, even if care is continuing exactly as the doctor prescribed. It is possible, however, that for financial or other reasons, not all medicines are taken or not all health care is utilized as prescribed. This type of incomplete treatment was not captured by the questionnaire.

The evidence presented here that money essentially is not a barrier to access to health care does not address a further question, whether patients who pay providers informally get the same service as patients who do not, once they have made contact with the provider. In its broader sense, the equal access principle requires that patients with the same health needs who seek care should receive the same treatment. That is, if non-paying patients receive lower quality care than paying patients, they face unequal access even though they have not been denied access per se. Although we did not seek to address the issue of differential treatment in detail in the framework of our study, the database from the TÁRKI-1996 study provided the opportunity to start exploring this topic.

7.3.3. DOES INFORMAL PAYMENT MEAN BETTER CARE?

We have looked at all three studies for which databases were available for secondary analysis. There are three aspects of care examined in the TÁRKI-1996 study where the impact of informal payments on patient care could be analysed: the service provided in the surgery, home visits and if the patient has to go to hospital. In each of these areas we looked for the most objective characteristics of the service provided by the family doctor. We finally selected five variables whose association with informal payments was analysed: whether family doctors listen carefully to the complaints of patients; how much time do they devote to the patient in the surgery; whether they visit the patient at home when requested; whether they visit patients without being called; and whether they enquire about the patients if admitted to hospital.

In the TÁRKI-1996 study the amount of informal payments to family doctors was not addressed except for specific services, such as home visits. Instead, respondents were asked whether or not they pay the doctor informally and, if so, is this regularly or just occasionally. For the analysis we first created a dichotomous variable by merging cases of regular and occasional ‘payers’ to identify ‘payers’ as opposed to ‘non-payers’, although where appropriate regular ‘payers’ were also considered separately.

Table 7.10. Association between informal payments and attention paid to patients by family doctors: TÁRKI-1996 study

Does your family doctor listen to your complaints carefully? (Q52)	Do you give money or gift to your family doctor? (Q81)				Total	
	Yes, regularly		No			
No	0	0.0%	28	2.9%	28	2.8%
Yes	27	100.0%	943	97.1%	970	97.2%
Total	27	100.0%	971	100.0%	998	100.0%
Test of statistical significance	Exact Sig. (2-sided)			Exact Sig. (1-sided)		
Fischer's exact test	1.000			0.459		

Note: *The Pearson Chi-Square test is not applicable, because there is one cell, whose expected count falls below 5 (0.76).
Source: Secondary analysis of the TÁRKI-1996 study [216]

Table 7.11. Association between informal payments and treatment time in the surgery: TÁRKI-1996 study

According to your estimation how much time does your family doctor spend exclusively on you per visit? (Q48)	Do you give money or gift to Your family doctor? (Q81)				Total	
	Yes, regularly		No			
Less than 5 minutes	2	7.4%	112	11.8%	114	11.7%
5 minutes +	25	92.6%	838	98.2%	863	88.3%
Total	27	100.0%	950	100.0%	977	100.0%
Test of statistical significance	Exact Sig. (2-sided)			Exact Sig. (1-sided)		
Fischer's exact test*	0.760			0.372		

Note: *The Pearson Chi-Square test is not applicable, because there is one cell, whose expected count falls below 5 (3.15).
Source: Secondary analysis of the TÁRKI-1996 study [216]

The results of our analysis are shown in Tables 7.10, 7.11, 7.12, 7.13 and 7.14. This shows that family doctors do not pay more attention to patients who pay than those who do not. Neither there is any significant difference in terms of treatment time in the surgery. This is the case even if only regular payers are considered.

Table 7.12. Association between informal payments and home visits denied by family doctors: TÁRKI-1996 study

Did your family doctor visit you last time, when you requested him? (Q73)*	Do you give money or gift to your family doctor? (Q81)				Total	
	Yes		No			
No	0	0.0%	7	2.7%	7	1.6%
Yes	175	100.0%	253	97.3%	428	98.4%
Total	175	100.0%	260	100.0%	435	100.0%
Test of statistical significance	Exact Sig. (2-sided)			Exact Sig. (1-sided)		
Fischer's exact test**	0.045			0.026		

Note: *Respondents, who requested home visits, at least once in the past 3 years prior to the survey; **The Pearson Chi-Square test is not applicable, because there are two cells, whose expected count falls below 5 (2.82).

Source: Secondary analysis of the TÁRKI-1996 study [216]

Table 7.13. Association between informal payments and uncalled home visits: TÁRKI-1996 study

Did it happen that your family doctor visit you without being asked? (Q76)*	Do you give money or gift to your family doctor? (Q81)				Total	
	Yes		No			
No	253	81.1%	1,031	90.3%	1,284	88.3%
Yes	59	18.9%	111	9.7%	170	11.7%
Total	312	100.0%	1,142	100.0%	435	100.0%
Test of statistical significance	Value		Degree of freedom		Asymp. Sign. (2-sided)	
Pearson Chi Square	20.047		1		0.000	

Note: *Question for the whole 1,500-head sample;

Source: Secondary analysis of the TÁRKI-1996 study [216]

Table 7.14. Association between informal payments and the attention of the family doctor paid to patients in hospital: TÁRKI-1996 study

Did your family doctor enquire about you, while you were in hospital? (Q115)*	Do you give money or gift to your family doctor? (Q81)				Total	
	Yes		No			
No	50	49.5%	164	61.4%	214	58.2%
Yes	51	50.5%	103	38.6%	154	41.8%
Total	101	100.0%	267	100.0%	368	100.0%
Test of statistical significance	Value		Degree of freedom		Asymp. Sign. (2-sided)	
Pearson Chi Square	4.277		1		0.039	

Note: *Respondents, who were in hospital at least once in the past 3 years prior to the survey;

Source: Secondary analysis of the TÁRKI-1996 study [216]

In contrast, the refusal to visit at home when requested by the patient, unsolicited home visits and enquires about hospitalised patients have all been found to be associated with informal payments. As shown in Table 7.13, the strongest association is

with unsolicited home visits, as almost 20% of ‘payer’ patients have been visited by their family doctor without being asked, while the corresponding figure for ‘non-payer’ patients is less than 10%. Furthermore, ‘payer’ patients can expect that their family doctor will always visit them on request (Table 7.12), and they have a greater likelihood that they will receive attention from the family doctor during a hospital stay (Table 7.14).

Nonetheless, the observed association between informal payments and the care provided by the family doctor must be interpreted with caution. First, while statistically significant, the differences between ‘paying’ and ‘non-paying’ patients are generally not especially striking. Second, a statistical association does not prove a causal relationship. Further, more detailed analysis is needed to explore, for instance, possible confounding factors, such as illness severity. Another important methodological issue is that giving informal payments in general was asked about in this study so it was not possible directly to link payment to particular episodes of care. Consequently we consider this analysis as no more than a first step in exploring the issue rather than a detailed explanation of the phenomenon. The evidence presented here indicates that informal payments might affect the service provided, but the situation is not at all straightforward and certainly not as clear, and worrying, as it is in FSU countries. On the other hand, these findings call attention to an important issue that requires further research.

7.4. Conclusions

So, how can we summarise the above findings? Certainly, the impact on equity of informal payments is not as straightforward as that with formal co-payments. In effect we have found no evidence that they deter access to care, and it seems that the rich pay more frequently than the poor. This may indicate that patients pay according to their ability to pay or that physicians price discriminate, at least when payment or non-payment is considered. On the other hand our findings show that informal payments do place a disproportionate financial burden on the poor, as we have found no significant difference in the average amount of informal payments among those who pay between the poor and the rich. Furthermore, according to our Kecskemét study, 20% of households make a special effort (using savings or depending on gifts) to cover these expenditures, and our first findings from the secondary analysis of the TÁRKI-1996 study indicate that informal payments may indeed influence some aspects of the care provided by family doctors. All these suggest that informal payments have a more

subtle impact on equity. It seems to impose a disproportionate financial burden (and possibly a negative impact on consumption of other necessary goods and services) and in certain cases may lead to differences in treatment, rather than preventing access to services per se. Nevertheless, we have taken into account the limitations of our survey, discussed in chapter 5, when we try to project our findings to the country as a whole. In general, our sample comprised economically more active households, which suggests that the poorer segments of the population may have been underrepresented. Respondent bias was more problematic in relation to household income than expenditures on informal payment, although we have experienced response rates better than those of the HBS of the HCSO. Recall bias might have also affected our findings, but this was probably less of a problem for not seeking care when needed because of financial reasons as such events may be more easy to recall. In addition, more research is needed to analyse the issue in detail, both in relation to financing (to examine the amounts paid by poor and rich patients for more specific services, such as certain types of operation) and service delivery (to explore further the impact of informal payments in primary care, as well as in other levels of care).

Although analysis of the impact of informal payments on equity is directly related to the policy importance of the phenomenon, we have used this approach to inform us about the validity of the 'donation', as opposed to the 'fee-for-service' explanation. While the evidence of a negligible deterrence effect and the finding of a larger proportion of 'non-payers' among the poor fit the 'donation' hypothesis better, differential access in terms of the standard of care argues against it. Further, the inequity in financing revealed, coupled with the fact that many households must make special arrangements to cover informal payments imply that there must be pressures, not necessarily overt, behind payments and that a 'coercion factor' does exist. It is the 'coercion factor' and the motivation for informal payments that we now explore in depth.

CHAPTER 8. MOTIVATION EXPLORED IN DEPTH

8. MOTIVATION: GRATITUDE OR COERCION?

In the previous chapter we explored the impact of informal payments on equity, relating our findings to the issue of motivation. While the evidence is strong enough to reject gratitude as the only motivating factor, it is not complete and convincing enough to exclude the possibility that the majority of informal payments are ‘donations’ rather than ‘fee-for-service’.

8.1. The need for exploring motivation in depth

First, the average sums paid informally are only a small proportion of average income even in the poorest quintile and individual sums vary widely even within income quintiles. Second, as we have noted before, the association between informal payments and the standard of care only raises the possibility of differential access, but does not prove a causal association. Third, the share of non-payers among those who utilise health services is substantial. Although non-payment fits better with the ‘donation’ hypothesis, in itself it does not refute the ‘fee-for-service’ hypothesis. We should know more about the reasons behind non-payment, but currently we know almost nothing. Fourth, the finding that 20% of households drew on savings or gifts from others to cover informal payments does not say anything about the remaining 80%. Although we have considered the use of savings or gifts incompatible with the ‘donation’ hypothesis, in the Keeskemét study we could detect such discrepancy in only 11% of the episodes of health care utilisation (10 out of 91 valid cases), i.e. savings were used to pay the provider informally, yet, at the same time, respondents said that payment was motivated by gratitude.

On the other hand none of these findings refute the ‘fee-for-service’ hypothesis, as ultimately it is the motivation of the actors that determines whether the payment was given truly voluntarily or was subject to coercion in its wider sense. The absence of a difference between ‘paying’ and ‘non-paying’ patients does not exclude, for instance, the possibility that patients paid in the hope of receiving better care (but did not get it).

Nevertheless, as shown in chapter 5, evidence from surveys of patient’s motivation is contradictory, suggesting that surveys may not be the best method to explore what motives lie behind payments to health care providers and, specifically, the extent of any coercion.

In this chapter we first revisit this issue by reviewing the findings of our Kecskemét study and the secondary analysis of the TÁRKI-1996 study. Then we seek to get to the heart of the conflicting survey evidence by analysing in-depth interviews with patients, who said that they paid because they were grateful, because it was customary or a combination of the two (which are henceforth together referred to as ‘non-coercive’ reasons for giving), complementing it with findings from the interviews with physicians and with other patients from the case study. We seek evidence of any inconsistency between the motivation stated and the circumstances of giving by looking closely for any manifestations of pressures on patients to pay, i.e. a ‘coercion factor’ in the interviews.

8.2. Motivation captured by questionnaires: survey findings revisited

8.2.1. SECONDARY ANALYSIS OF THE TÁRKI-1996 STUDY

As we pointed out in chapter 4, the TÁRKI-1996 study is peculiar in that interviewers asked about the motivation of giving as an open question and answers were subsequently categorised according to the coding scheme used in the OTKI-1972-73 and 1981 studies. To explore the pattern of motivating factors identified we carried out a secondary analysis of the data looking at the responses, which, if the respondent mentioned more than one reason for giving, were coded separately in up to five variables, presumably in the order they were mentioned. Table 8.1 presents the distribution of the first answers given, while Table 8.2 provides a more detailed analysis including multiple answers, which were categorised into ‘non-coercive’ (gratitude, custom or the combination of the two) and ‘coercive’ motives (others, including the category of ‘other’).

Table 8.1 Motivation of informal payment to family doctors, first answer: TÁRKI-1996 study

Why do you give? (Q82)*	Frequency	Valid percent (with 95%CI)
gratitude	169	54.2% (48.5-59.8)
others give as well, it is customary	64	20.5% (15.9-25.1)
it is expected	15	4.8% (2.4-7.2)
to obtain better care	14	4.5% (2.1-6.8)
only this way could one get good care	1	0.3% (0-1.0)
other	49	15.7% (11.6-19.8)
Total	312	100.0%

Notes: *Open question, multiple answers were possible. First answer among those, who gave money or gift to the family doctor. More than one motivating factor was named in 16% of the 312 cases.

Source: Secondary analysis of the TÁRKI-1996 study [216]

Table 8.2. Motivation for informal payment to family doctors, all answers: TÁRKI-1996 study

Why do you give? (Q82)*	Frequency	Valid percent (with 95%CI)
Gratitude only	146	46.8% (41.1-52.4)
Customary only	40	12.8% (9.0-16.6)
Customary and gratitude	12	3.8% (1.7-6.0)
Gratitude and customary	0	
'Non-coercive' total	198	63.5% (58.0-68.9)
'Coercive' motivating factors (expected, better care, only this way could get good care)	39	12.5% (8.8-16.2)
Other	40	12.8% (9.0-16.6)
'Coercive' total	79	25.3% (20.4-30.2)
'Non-coercive' and 'coercive' mentioned together	35	11.2% (7.6-14.8)
Total	312	100.0%

Notes: *Open question, multiple answers were possible. Summary of answers among those, who gave money or gift to the family doctor.

Source: Secondary analysis of the TÁRKI-1996 study [216]

As can be seen, the findings from this secondary analysis seem to support the 'donation' hypothesis with almost two-thirds of the respondents mentioning exclusively 'non-coercive' reasons, among which gratitude is the most important motive with more than 50% of the respondents mentioning it alone or in combination with 'it is customary'. Of course, such results are in sharp contrast with the findings of the TKK 1985 study and so they add to the confusion, especially if we extend our analysis a little further.

In the TÁRKI-1996 study pressure to pay exerted by the family doctor was addressed in a separate question, answers to which are analysed in Table 8.3. If we collate answers to this question with answers to the question on motivation, we can see that almost 20% of those who cited exclusively 'non-coercive' reasons for informal payment felt such pressures. In contrast almost half of those who said that they paid because it was expected also stated that they never felt such pressures. These inconsistencies reinforce our suspicion that survey questionnaires (even with open questions) are inappropriate tools to capture the motivation behind informal payments, and consequently it is not possible to determine the validity of the gratitude payment concept solely on the basis of survey findings.

It is interesting to note that 13% of the respondents gave reasons that did not fit in the predefined categories. This relatively large proportion again shows the ambiguities that surround the issue. Unfortunately, it is not possible to say anything more than this, since the original answers are not available in the database.

Table 8.3. Perceived pressure to pay and its association with the motivation of informal payments to family doctors: TÁRKI-1996 study

Have You ever felt that you would receive more thorough examination if you paid the doctor informally? (Q99)*		Frequency	Percent	Valid percent (with 95%CI)
Valid	No	1,120	87.2%	87.4% (85.6-89.3)
	Yes	144	11.2%	11.3% (9.5-13.0)
	Do not know	17	1.3%	1.3% (0.7-2.0)
	Total	1,281	99.7%	100.0%
Missing		4	0.3%	
Total		1,285	100.0%	
Association of perceived pressure to pay with stated motivation				
Patients, who felt pressure, but stated that they paid because of 'non-coercive' reasons (N=198)		38		19.2% (13.6-24.8)
Patients, who stated they paid because it was expected by the doctor, but said that never felt pressure to pay (N=28)		13		46.4% (27.6-65.3)

Notes: *Respondents who had contact with the family doctor at least once in the past 3 years prior to the survey.
Source: Secondary analysis of the TÁRKI-1996 study [216]

8.2.2. FINDINGS FROM THE KECSKEMÉT STUDY

The Kecskemét study went further than the TÁRKI survey in several respects. We offered predefined answers, including the option ‘other’, to choose from in the question of ‘why?’ (see Question 27 in Appendix D4.), but we also addressed the so far totally neglected question of ‘why not?’ (see Question 33 in Appendix D4.). For both we have carried out a detailed analysis of the option ‘other’. Most importantly, however, we selected those cases where respondents cited ‘non-coercive’ reasons for giving and sought a follow-up interview about the episode of health care utilisation in question. We will present the findings of these in-depth interviews later in this chapter.

8.2.2.1. Motivation for informal payments

Table 8.4 summarises the motives for paying informally identified in the Kecskemét study. The findings appear to support the ‘donation’ hypothesis, as gratitude is mentioned most frequently, in almost 60% of all cases, followed by ‘it is customary’ with 40%. Overt coercion was rare, in only 1 of the 91 valid cases, with other ‘coercive’ reasons selected in less than a quarter of cases when each is considered separately. It must be noted, however, that the number of people who paid in cash and for exclusively ‘non-coercive’ reasons is only 21, or 23.1% of all cases (95%CI 14.2-32.9%), while the number of people whose sole motivating factor was gratitude was only 11, or 12.1% of the total (95%CI 5.3-18.9%).

Table 8.4. Motivation for informal payments: Kecskemét study, 2001

Q27. Why were the additional contribution made?*	Frequency	Percent (with 95%CI)
was grateful*	53	58.2% (47.9-68.6)
it is customary*	37	40.7% (30.4-51.0)
it was forced*	1	1.1% (0-3.3)
expedite treatment*	6	6.6% (1.4-11.8)
obtain more attention form the doctor*	22	24.2% (15.2-33.2)
obtain more attention form the nurse*	13	14.3% (6.9-21.6)
obtain better quality medicines*	1	1.1% (0-3.3%)
establish good relationship with physician for future treatment*	12	13.2% (6.1-20.3)
extra hotel services (single room, TV in room, better food, etc.)*	1	1.1% (0-3.3%)
physician provided sick leave certificate*	0	
physician provided disability certificate*	0	
other*	16	17.6% (9.6-25.6)
of which:		
health workers are not paid enough**	2	2.2% (0-5.3)
other 'extra' service (home visit during weekend)**	8	8.8% (2.9-14.7)

Notes: *See Appendix D4; Multiple answers were allowed, N=91. **Recoded from the category of 'other';

Furthermore, the analysis of ‘other’ responses has revealed that this category is almost exclusively related to ‘coercive’ motives, although in its broader sense. The information available is not sufficient to categorise two cases, but the findings concerning the remaining 14 are as follows.

Two patients paid because of the low salaries of health workers, while a further seven were seeking ‘extra’ services, with three seeking home visits and four seeking contacts (either at home or at the surgery) at the weekend or after surgery hours. One patient wanted to go home before the scheduled discharge. In chapter 3 we argued that a crucial element of the definition of informal payments is ‘entitlement for services’, and we hypothesized than in a health care system that is unable to deliver a reasonable standard of care to everybody and where entitlements to services are not clear, patients make their own decisions about what they can expect to receive free and what not, regardless of its official status regarding the benefit package. We argue that home visits are a good example of this as the borderline between justified and unjustified home visits is blurred. Although one can argue that the concept of ‘extra’ services does not contradict the ‘donation’ hypothesis, secondary analysis of the TÁRKI-1996 study shows that there is indeed a substantial difference between the frequency of informal payments to the family doctor in relation to consultations in general (23.4% (95%CI 21.0-25.7%)), and when home visits are considered alone (45.8% (95%CI 42.8-48.8%)). Should someone feel a need to express gratitude if a particular service is provided at

home but not if the same service is provided in the surgery? Two other patients provided evidence that can be interpreted as supporting this concept of ‘extra’ service. One paid because s/he received better care than s/he expected, while another paid because s/he felt that otherwise s/he would be a ‘free-rider’ in the system. The first case may illustrate how individual reassessments of entitlements may not be manifested by discrimination between different services, but rather in terms of the expected standard of care associated with a particular service. The second case may represent the extreme of reassessed entitlements insofar as ‘free services’ are seen as an illegitimate expectation.

Finally, the remaining two cases fit well with the lost ‘trust’ hypothesis suggested in chapter 3 and Appendix F, highlighting another aspect of the ‘coercion factor’. One respondent commented that it is not possible to get acceptable quality of care without informal payment, while the other said that the “*risk is lower*” this way, i.e. one cannot be certain that one will get the necessary treatment without paying the provider informally.

8.2.2.2. Motivation for non-payment and a new understanding of ‘custom’

The analysis of the question ‘why not?’ offers further insight into the motivation issue. Table 8.5 reports the distribution of frequencies of the specified options and the content of the category of ‘other’, which was disaggregated into new categories where these were cited at least five times. This shows that the existence of public coverage and within that social insurance is the most frequently mentioned reason, while having private insurance is negligible. This suggests that the majority of the population are aware of the fact that health care providers are paid by the social health insurance fund in Hungary. Sixty-three percent (95%CI 59.1-67.2%) cited exclusively the option of public coverage, but 36.3 % (95%CI 32.3-40.3%) provided other reasons, of which the largest category is that the ‘doctor is a friend’. These results offer new insights into the motivation of those who do pay.

Looking at what other options have emerged from the study, it is conspicuous that gratitude, or rather the lack of gratitude, has not been mentioned at all. There were only three cases where the reason for non-payment is dissatisfaction with the provider or with the service provided (“*the physician did not deserve it*”, the patient “*did not recover*”, and “*bad experience*”). Conversely, ‘custom’ has been mentioned frequently, albeit the context of ‘non-paying’ has given a different interpretation to the

concept than what we have assumed in the context of giving, an interpretation that contradicts the ‘donation’ explanation of informal payments.

Table 8.5. Reasons for non-payment: Kecskemét study, 2001

Q33. You told me that the services were not paid for, why?*	Frequency	Percent (with 95%CI)
Paid by the government*	9	1.6% (0.5-2.6)
Paid by social insurance*	403	69.7% (65.9-73.5)
Paid by private insurance*	3	0.5% (0-1.1)
Doctor is a friend (relative, colleague**)*	48	8.3% (6.0-10.6)
Other*	182	31.5% (27.6-35.4)
of which:		
Because the service did not justify it**	47	8.1% (5.9-10.4)
Not expected**	46	8.0% (5.7-10.2)
No money**	37	6.4% (4.4-8.4)
Not accepted**	10	1.7% (0.6-2.8)
Disapprove of informal payments**	8	1.4% (0.4-2.4)
Services are free**	7	1.2% (0.6-2.8)
The care is in progress**	5	0.9% (0.1-1.6)
Paid by the employer**	5	0.9% (0.1-1.6)

Notes: *See Appendix D4; Multiple answers were allowed; N=578. **Recoded from the category of ‘Other’;

Except in two cases, the statement ‘it is not customary to pay...’ and ‘I/we do not pay...’ is always mentioned by respondents in connection with a specific health service (*“we do not pay the family doctor”, “we do not pay in the polyclinic”, “we do not pay for this service, only in hospital”*) or illness (*“in the case of flue it is not customary”, “small [mild] disease, we pay if it is big [serious]”*). Taken with similar responses (*“it was only pulmonary screening”, “I went for a prescription only”, “we pay in other cases, but not this time”, “we did not call the doctor to visit at home, but went in [to the surgery]”, “it was not an operation”*), including qualifications related to frequency of utilisation (*“we rarely visit the doctor”, “I rarely go, and it happens quickly”*), we have constructed the category ‘because the service did not justify it’.

In the other ‘custom’ related responses, payment was not mentioned in connection with the service, but with a specific provider (*“it is not customary to pay this physician”*), suggesting that the attitude of physicians is also a ‘custom-forming’ factor. Taken with similar responses (*“the physician is very kind”, “he would not accept it”, “not ‘that’ type of physician”, “we did not have to pay at this provider”, “I get the same treatment [without informal payment], it is not expected”, “they do not expect it”*) we have created the category of ‘it was not expected’.

The existence of both service-related and provider-related 'customs' suggest that, in the context of informal payments, the meaning of custom is not clean-cut, insofar as it has a closer association with what is expected than the gratitude for the outcome of treatment. Seen this way, the 'custom' motive fits better with the 'fee-for-service' than the 'donation explanation of informal payments.

It is worth noting that the category of 'it was not expected' is closely related to the category of 'doctor is a friend (relative, colleague)', insofar as there is no expectation to pay among relatives, friends or colleagues, and these two categories together include about 16% of the answers. The link between them is well illustrated with responses, such as *"it is not expected from me, because I am a health worker"*.

Another finding that is incompatible with the 'donation' hypothesis is that, in 6.4% of cases, patients did not pay because they did not have money. If there was no pressure to pay, why should anyone mention this? This reason of 'non-payment', as well as the other two ('it was not expected' and 'the service did not justify it') suggest that there are cases of health care utilisation where the 'coercion' factor exists, even if it is not eventually manifested in actual payments.

However interesting these findings are, the proportion of such cases is not large enough to question the dominance of 'non-coercive' motivating factors, which, despite somewhat contradictory evidence, is the common conclusion of most of the surveys discussed here. On the other hand, this does not exclude the possibility that the 'coercion' factor exists in the majority of cases if surveys fail to capture motivation accurately. Indeed, the above findings strengthen our suspicion that quantitative surveys are not appropriate for this task as it is not possible to explore in sufficient depth each response. To shed light on this issue we used in-depth interviews and used this rich source of knowledge from individual cases to explore whether the motives suggested by the questionnaire correspond to the findings of the in-depth interviews.

8.3. Pressures on patients to pay: the 'coercion factor'

We analysed in-depth interviews with the 21 patients and the 31 physicians in two phases. First, we looked for manifestations of internal and external pressures on patients to pay, which we termed the 'coercion factor'. In doing so we have concentrated mainly on patients' interviews, but also complemented the findings with the perspectives and experiences of physicians. Second, we looked at the interviews with those 11 patients who exclusively cited 'non-coercive' reasons of giving in the

survey (6 citing 'gratitude', 4 stating 'it is customary', and one mentioning both), to identify manifestations of the 'coercion factor' in individual cases.

It should be noted that we deliberately did not want to confront the interviewees with their responses in the survey. This might have suggested that there was a right or wrong answer for the question about motivation. However the issue came up in most of the interviews anyway.

In the following sections we refer to the interviewees by a letter and a number. The letter 'P' stands for patient interviews, and the number corresponds to the numbering in Appendix B and C. The letter 'D' stands for physician interviews, but in these cases the numbers do not refer to any particular list of interviews, to avoid identifying interviewees.

8.3.1. IDENTIFYING THE 'COERCION FACTOR': THE MANIFESTATIONS OF DIRECT AND INDIRECT PRESSURES

The interviews with patients and physicians presented here provide excellent illustration of the point raised in chapter 3. Although the key feature of the gratitude (donation) explanation of informal payments is that they are given voluntarily, it is not reasonable to interpret coercion solely as arising where physicians expect and demand payment from patients. The wealth of evidence summarised below implies that coercion must take a much wider meaning that goes beyond explicit enforcement and incorporates pressures from other sources, such as the perceived failure of the health care system or from patients themselves, and which allows for the subtleties of everyday life. For instance, the decision to pay informally in the hope of receiving better care is different depending on whether the expectation is for 'premium' services or simply in response to a health care system that frequently fails to provide even a minimum standard of care.

While we have concentrated on the 'coercion factor' in our analysis, there are other aspects of the phenomenon, such as the attitude of patients and physicians towards informal payment, or the mechanism of determining the amount of informal payments, that can be incompatible with the benign 'donation' explanation. The following sections now examine these issues.

8.3.1.1. Coercion as a manifestation of distrust in the health care system

Interviews with patients demonstrated how the act of giving does not happen in isolation, independent of individuals' previous experiences with the health care system in general, and with informal payments in particular. In many cases, these experiences,

most often involving a hospital stay, in particular operations, serious illnesses or deliveries, have emerged in the course of interviews even when not asked about directly.

Past experiences with health care

Although not all interviewees report negative experiences, the picture that emerges is far from complimentary about the Hungarian health care system. All, but two respondents (P07,P17) personally experienced deficiencies in services provided, ranging from poor service to inadequate clinical standards, and from minor problems to serious negligence and potential malpractice. Interestingly, three respondents (P04,P05,P09) initially emphasised positive experiences but subsequently admitted to experiencing poor care as the interview progressed. One expressed a reluctance to talk about failings, as if he was afraid of some kind of retaliation: *"...one can see a lot of things, which I don't want to speak about, because it isn't related [to my care]...there are things, which are ...better not to tell, you know"* (54-year old man, P09).

Deficiencies reported by interviewees include a lack of hygiene:

"I wasn't satisfied with the whole environment, the dirt, the fug, the smell, the operating theatre was so filthy, that I contracted an infection, a purulent peritonitis and the pus was flowing out of me for half a year."

said a 52-year old woman (P02; similar comments P04,P08,P15,P19,P21). A 33-year old woman complained:

"...the condition of hospitals, they [the walls] are nitrous, and cockroaches are running on the corridor, I was sitting there and the cockroaches were running about, this is a rather disgusting experience." (P08; also P19)

They reported long waiting and short treatment times:

"...if I go to the family doctor or the polyclinic then the doctor, fifty-thousand patients are sitting there, has only two minutes to see me ...Now it's not possible to diagnose anything in two minutes."

and

"...I had to wait a lot, they were sending me from one building to the other ...I was ordered to come in early morning, because you have to wait to be seen, I've waited for two weeks, and then I had to come in 8 o'clock and I went home at half past 1 in the afternoon." (44-year old woman, P03; also P02,P05,P12,P13,P15)

Respondents also cited lack of supplies, obsolete equipment, and insufficient and inedible food in hospitals. For instance a 54-year old man summarised his experiences as follows:

"..It's true that the service was public during the state [socialist] era, but everything was available from bandages to ...medicines, everything was there. And now one cannot be certain that all medicines in the hospitals are there." (P05; also P03,P08,P09,P13,P15,P19)

Several interviewees complained that they had to bring their own medicines to the hospital:

"...not long ago, [my mother] was taken to hospital, and then the telephone rang in the evening, it was the physician on night duty. Tomorrow we have to bring in this and that medicines, because they cannot provide it." (29-year old woman, P13; also P07,P11,P15,P19,P20)⁴⁹

Other complaints related to lack of attention, insensitivity, and rude and rough behaviour with patients. For instance a 63-year old woman complained about her mother's case as follows.

"They [the nurses] don't want to bring it [the bed-pan] in, and if they bring it in they keep it under the patient for hours ...it happened with my mother, she was already confined to bed, and then they left it under her for the whole morning and it spill and the other patients tried to help her somehow..." (P14),

or

"...it was written on my bed head board with large red letters, the medicines I must not be given, and the nurse came, brought the injection and wanted to administer it. I asked her 'what do you want to give me?', and [she replied] ... 'why does it matter for you? Algopyrin' she said. I told her not to give the injection, because I'd suffocate right there..." (54-year old woman, P05; also P11,P13,P15,P16)

Others complained about nurses and physicians smoking in the corridor (P04,P05) and several patients commented on the insensitive behaviour of certain physicians and the inadequacy of the information they provide:

⁴⁹ I have experienced this personally during an interview with a physician. When we were talking there was a knock on the door and a man came in and handed over a large bag of pharmaceuticals. The physician explained the situation to me. They asked the relatives of inpatients to look for their unused medicines at home and bring them in as they may be able to use them in the hospital.

"...I tried to ask about things, but I never got the answer, and we only learnt on the day of the operation that both of his eyes will be operated not just one ...and when my husband had enough courage to say that we're told that after the operation our child wouldn't have to wear glasses yet now we learnt that he'd need stronger ones, she almost threw us out of her surgery. She started to yell at us inarticulately that we shouldn't take this as a question of aesthetics, and 'dear father, you have to acquiesce that this child will wear spectacles and subject to mockery for the rest of his life'. Now then, I don't think that this is the appropriate way to inform a parent." (33-year old women, P08; also P04,P09,P10,P11,P19,P21)

There were also examples of misdiagnosis, mistreatment and malpractice; for instance a 54-year old woman (P09) recalled her experience as follows:

"...they said 'please don't be angry' and they apologised that the [operation] wasn't successful and it has to be repeated. They did this without anaesthesia ...and now I've double vision [diplopia], which has remained with me ever since. Because, when I was in XY, this delay, these 10 days meant a lot. Had they operated me there, my vision wouldn't be impaired." (P05, also P04,P07,P08,P10,P13,P16)

This far from favourable picture of the health care system is reinforced by interviews with doctors (D08,D09,D10,D15,D19,D21,D23,D24,D25,D26,D29,D30,D31). Apart from complaining about the lack of money, manifest by low salaries (D03,D04,D05,D09,D10,D11,D14,D19,D20,D21,D23,D24,D26,D27), shortage of supplies (such as the aforementioned drug problems (D14,D15,D23,D25,D26)) and inadequate instrumentation (D10,D23,D31), respondents emphasized the insensitive, impersonal care, which arose from their adverse circumstances, in particular a high workload coupled with very low remuneration. Some described their practice as 'conveyor-belt care' (D13,D21,D29), a phrase also used by patients (P08), while another respondent used the term 'treadmill' (D24):

"...One works in a dilapidated underground surgery so that there are 50 patients sitting in front of my door, I have no assistant and I'm working until 6 p.m. ...I wouldn't like to say that this is the fault of doctors, nurses or assistants. The organisation of the health care system doesn't allow us to treat the patients as humans. This is a conveyor-belt on which we send number 2 here and number 3 there..."

and continued:

"...how many patients are there, who're taken for examination into another health care institution, and who're waiting for the ambulance until 8 p.m. and are left out there, sitting in the corridor ...They've remained with an empty stomach, having gone through a painful intervention ...They're cold, because they only have a night-gown and a bath-gown on, and they're sitting there waiting for the ambulance to arrive. And nobody goes and asks 'shall I bring you a cup of hot tea or warm soup', or 'wouldn't you like to lay down somewhere and I'll try to find a bed'..." (D29)

While there is no agreement among physicians on the extent of these problems, in a sense the admission of what goes on is even more devastating than that of the patients:

"...The state [public] health care is rotten to the core, or to put it more nicely it's finished ...despite the fact that everybody is very helpful, it's not possible to create something from nothing." (D26; also D30)

On the other hand, not all patients have had adverse experiences with health services and not all reached overall negative conclusions about the system. Unlike the seven interviewees who expressed, one way or another, a general dissatisfaction with the health care system (P01,P02,P06,P08,P09,P15,P18), such as:

"...the truth is that the health care system is in 'frog perspective'⁵⁰, the state has taken its hand off of everything. The long and the short of it, is that we mustn't be ill..." (52-year old woman, P06),

seven interviewees had favourable opinion at least about the actual episode of care, we wanted to explore (P04,P05,P07,P08,P09,P12,P17), for instance:

"...[the circumstances] are simple, but superb, so that the cleanliness is very good and I was very satisfied ...it's totally different when patients complain that if they don't take their medicines with them, then they may not get them..." (59-year old woman, P07)

As some interviews show, the point of reference also matters in this respect. Three of the respondents mentioned experiences abroad, one in Canada (P05) and one in Austria (P03), in each case accentuating the perception of a failing Hungarian system, while another experience in the UK placed the Hungarian health care system in favourable light in the eyes of the interviewee:

⁵⁰ There is a Hungarian phrase, if the standard of something is extremely low: 'it is under the bottom of a frog'. The respondent probably wanted to use this phrase.

"...I know that the situation is no way better in the west. My son was in England for two years, and in the second year he had his four-month old son with him ...and they took him to the doctor, and the doctor didn't even look at him, only the nurse did something, and the doctor was just sitting somewhere, hanging about. So if I compare to this, then I say that Hungarian doctors or the services provided are much better." (63-year old woman, P14)

This case also highlights that previous experiences do not have to be one's own to influence one's judgment about the situation. One of the two respondents who did not have bad personal experiences cited several shocking examples from different sources including relatives:

"...As I say, we have ...no chronic illness in the family ...but, my sister-in-law, my husbands older sister, who's suffering from a very serious problem ...rectal cancer ...she told me, that it's very probable that it's been a malpractice ...so in these cases, even if I don't have an own experience, but I hear in my neighbourhood that there's such a problem, than you really say that my God it's good until we've to go to the doctor...",

or friends or acquaintances:

"...The truth is that I've heard not the best opinions about XY hospital. Particularly, one of the employees told me, that 'you are crazy, lest you enter here, you cannot imagine, how many 'botchy' patients lay here after operations' and she says 'I don't recommend it to you'",

and the media

"... it was a horrible period, when we heard the appearance of the 'black angel' [a nurse, who killed incurable patients on her own intention] in the radio, it was exactly this period. It was indeed frightening, because from the radio, [we heard] that the case was being investigated..." (59-year old woman, P07)

Other possible sources include those sharing a room in the hospital (P11) or, more generally, word of mouth:

"...for instance there's a certain obstetrician ...he had a mother, who died ...the mother and the baby as well ...and it was forgotten, because it happened with doctor X, who's a 'big head', a very good physician, eh, it happens. But if it was another one, not so famous, who hadn't yet been to America on a study trip, then it would be such a rumour that the whole town would know." (41-year old woman, P11)

Furthermore, it was conspicuous that positive experiences have frequently been coupled with contrasting bad ones. This suggests that virtually all contacts with health care providers took place within a context of general uncertainty about the care one can expect:

"...But you can hear startling things. When one is admitted to the hospital as an 'ordinary' patient anything can happen." (59-year old woman, P07),

and

"In general the experience there [in that particular hospital] is that they're [physicians and nurses] kind to patients, not like elsewhere." (41-year old woman, P12; also P17)

These experiences, both personal and second-hand, increase the general uncertainty that patients face (because of the information asymmetry between physicians and patients and the risk that treatment might fail even in the best circumstances). One physician conveyed this well by citing a media story:

"There are large numbers of ...false articles that are published [in the media] about health care. ...A year ago there was a case on TV ...that the vigilance of anaesthesiologists saved the life of somebody, because an assistant was angry with ...the doctor ...and ...poured something into the narcotic machine, and if they hadn't noticed what was there, then the patients would have died. ...And imagine that after this somebody will go for an operation ...he's afraid of the operation anyway, and [in addition] such things can happen. 'If it isn't discovered accidentally then I'll die. ...It's terrible, ...will I survive ...if such thing will really happen, as we've heard on TV?'" (D27)

Health care failures thus induce distrust of the health care system. As a 59-year woman put it:

"...so at home he [the patient] has to take drugs. And then there isn't [that type of medicine in the hospital], simply they don't have it, or it isn't possible to buy it, or they have a different type, and then the patient has no trust and has the drugs brought in..."

and went on, saying that:

"...so anyway this obviously hasn't strengthened our faith and trust, since these are horrible things, that we've heard..." (P07)

But how do these experiences result in informal payments?

The connection between past experiences, distrust and informal payments

The most obvious way is that they arise as patients seek to avoid such failings. As a 29-year old woman recounted in connection with the illness of her mother, who was in hospital many times, but discharged early without recovering fully:

“Respondent (R): ...she was discharged, for example, on Thursday and had to go back on Sunday, and this happened twice or three times.

Interviewer (I): And did you complain about this? Or did you try to do anything else to solve this problem?

R: To be honest, I cannot complain. Is it good if I complain?

I: I don't know, I'm just asking.

R: So, I'd put it this way, that I cannot decide whether I'm better off if I complain or if I don't. Or can it rather be solved by money?

I: And what do you weigh in your mind in such a situation? You told me that you cannot decide...

R: Er, that what's better for my mum. Because if I complained, most probably, I wouldn't complain to the physician, who did this to her, as maybe the situation would get even worse.” (P13)

If failure to pay is associated with an unsuccessful intervention, patients can easily make a connection. As one woman, who did not pay and whose goitre operation failed, said:

“...the truth is that I know that if I choose a doctor myself, then I can be certain that he expects money. [So I didn't choose, but] I knew that somebody would operate me anyway but the operation wasn't successful. ...For instance, now if I had to go to XY hospital and I'd need an operation, whatever it is ...I'm sure I'd select another doctor...” (P19)

The interviews reveal that, in this respect, low salaries also matter, insofar as they generate a view that physicians need informal payments. It is clear that most respondents are aware of the low salaries of health workers (P01,P02,P03,P05,P06,P08,P09,P10,P13,P14,P16,P19,P20), and although not all know the exact amounts, they use terms such as ‘they are in need of it’, ‘they are dependent on it’, ‘they are forced/compelled to accept it’, ‘they have no choice, but to accept it’ (P01,P06,P10,P14,P20). Two respondents made the connection between poor performance and low salaries as follows:

“Look, in health care there're loads of patients and few physicians, and they aren't paid enough ...and so, don't let me say what they're compelled to do, thus if you don't put that certain thing [envelope with informal payment] there ...in my

opinion, there're many patients and the physicians haven't enough time." (47-year old man, P20),

and:

"They're on night duty, and run around and they deserve more, and then [if they were paid enough] they'd approach things very differently right away." (52-year old woman, P02; also P07),

while another interviewee made an interesting comparison with lawyers:⁵¹

"...I wouldn't say that this applies to solicitors as well, because when we had a case and I saw that he read it from the computer. For 15-minutes work, dear me, he asked for 15,000 forints⁵². I couldn't have imagined giving gratuities in addition. I was rather upset..." (59-year old woman, P07)

The first example also illustrates how this process works at a more general level, since the behaviour of patients is influenced not just by the failings in the system that are experienced, but also by previous direct or indirect experiences with informal payment itself (P01,P02,P03,P07,P08,P09,P10,P11,P12,P13,P14,P15,P16,P18,P19,P20, P21):

"...when I was pregnant, I had a room-mate from XY. She was brought to the hospital by the ambulance, and she had a Caesarean section ...and just before discharge, since she didn't have her 'own' obstetrician, when the senior registrar said during ward-round that her stitches should be removed, each physician pointed at the other that this one would do it, or that one, or another one..." (29-year old woman, P13; and P14 a very similar example)

General distrust: 'It is not possible to receive quality care without payment'

Together these experiences can lead to extreme distrust in the system, with a belief that it is not possible to receive good quality care if one does not pay:

"R: ...to tell the truth, doctors promise something, which doesn't function.

I: What are you thinking of?

R: This is a generalisation, it doesn't apply to everyone, but doctors promise to help others but don't do it without money. There're cases where, if someone doesn't pay, then he can die."

⁵¹ It is interesting to note, that in Hungary informal payments to solicitors did exist during the communist regime [e.g.200]. It would be an interesting further research direction to assess, what happened with solicitor's gratitude payments, and why.

⁵² €60.

and she continues:

"...if somebody has acquaintance they get a private room and special treatment. I had a private room, too, during two weeks. I cannot complain about the treatment either. But had I been an ordinary little woman who went there, I wouldn't have got this treatment." (32-year old women, P01; also P02,P06,P18,P19,P20,P21)

As another patient said:

"...I'm not sure that this is due to doctors, but patients who do believe that if they don't give they'll not receive acceptable care." (63-year old woman, P14),

a view echoed by a physician:

"...there's a part of the population who simply cannot imagine that it's possible to get adequate care without payment." (D04)

Distrust with anxiety: 'I did everything that I could do'

Nevertheless, there is much uncertainty about the need to pay, with the association between the standard of services and informal payment being not unequivocal. Just as the experiences with health care system performance are heterogeneous, so are those related to informal payments (P10,P11,P12,P17). Just as it is often difficult for lay persons to establish whether an unsatisfactory outcome was due to provider negligence (P09,P13,P14,P17), it is not always easy to establish the actual impact of an informal payment (P10,P14,P20). This uncertainty seems to influence the decision by increasing the anxiety that is a common accompaniment of medical treatment:

"R: ...for instance there was somebody, who came in the same time when I did and she didn't have an arrangement with a physician that he'd operate on her. She was in the same room yet I experienced absolutely no difference [in terms of the services], and so from this experience I've drawn one or two lessons...

I: And may I ask you what this was?

R: ...That gratitude payment is important only for us. Maybe it's for my own inward peace." (53-year old woman, P17),

As another woman explained:

"...when I was here in the gynaecological department, then the fact that I knew my husband had given money meant that I felt safe ...It's stupid, but I did feel that way. I had a better state of mind."

When she compared her experiences in the state health care system with those in a private hospital she said:

"...I don't feel this anxiety there ...It's totally different when I go there." (44-year old woman, P03)

Recalling chapter 4, these accounts correspond well with concept of 'psychic security' as one possible motive for informal payments in the TK-1985 study (but those researchers did not explain what they meant by it). Two interviews with physicians explore this issue further:

"R:...[informal payment is motivated by] the fear of the patient that ...if they don't give then no-one will pay attention to them.

I: And why do you think patients fear this?

R: In state health services, a surgical ward can be extremely overloaded and [even if] they work according to the professional requirements, ...the patient can still think that if I give I buy his [the doctor's] attention. And if I am on the operating-table, who knows that I'll survive or not, I must do everything in order to have a successful operation. If I did everything and I die, I cannot help it..."

and later on:

"...maybe I will manage to get something, maybe they'll use better equipment, maybe they'll use better thread, the patient obviously cannot know this, since the surgeon won't discuss this with him, but this thought that I've done everything to get the best service..." (D28),

while another physician put it this way:

"...for him [the relative of the patient] to be at ease, that his relative has got everything that's possible, he has to pay ...I think this [informal payment] is such a means, which can help ...this 'sacrifice' ...I put this, too, in that what I do for him [the patient]." (D04; and D13,D19,D23)

Thus informal payment becomes part of this 'everything', and non-payment can increase the natural anxiety that accompanies health care interventions inasmuch as patients and relatives failed to do everything if they did not give, even if they cannot be sure about what impact informal payments might have. This is a less obvious manifestation of the coercion that can result from distrust in the health care system, than the 'I have to pay, because that is the only way to receive adequate care' approach.

Nevertheless, these views cannot be universal as otherwise everybody would pay for every service. The fact that they do not suggests that the decision-making is more

complicated. In the next section we explore the association between informal payments and particular services, and then look at the subtle ways by which direct coercion can be brought to bear by providers.

8.3.1.2. Coercion as unclear entitlements and extra services

The empirical literature shows that informal payments are unequally distributed among physicians according to levels of care, specialty and, in certain cases, to types of service. Although one of the distinctive features of gratuities is that they are not given to physicians in exchange for exceptional services (i.e. payment is not service oriented), the fact that informal payments depend on the attributes of services does not, in itself, question the validity of the gratitude payment concept. There is no reason to assume, for instance, that the feeling of gratitude cannot increase with illness severity or complexity of the procedure performed. This is a possible explanation for more extensive informal payments in inpatient care compared to outpatient care (a finding confirmed by our interviews with physicians (D04,D16)). Similarly, patients may feel more intense gratitude if doctors can solve a problem that is particularly troubling (painful, severely limiting etc.). It appears that individuals attach different degrees of importance to different services (for instance because they affect sensitive or intimate areas), which, at least partially, can explain the differences in willingness to pay, but at the same time does not contradict the 'donation' explanation of informal payments. For instance, an interviewee, talking about her experiences in private medicine, said:

"I: Have you, or your family ever visited a private doctor with some problem?..."

R: I went to the otologist once, because ...I feel my ears so much, if I, myself, touch it, it develops an inflammation immediately, and it hurt so much I was afraid to go to the polyclinic. And so I went directly to a private doctor" (P11; also P08;P20),

while a physician reflecting on why obstetrics and gynaecology is among the best paid specialties says:

"...eventually there's an intimacy, there's a sensitivity of women, ...and the expectation of the public, that healthy women come here ...to bear a child, ...therefore any mistake cannot be made, ...as there are two lives involved..." (D19; also D09)

The interviews, however, revealed other characteristics of the distribution of informal payments between and within specialties, types of services and settings that are

incompatible with the donation hypothesis of informal payments and consequently require an alternative explanation.

'Non-paying' specialties

In chapter 4, we have noted that there are medical specialties, such radiology and other diagnostic fields, where informal payment is virtually non-existent. Our interviewees not only confirmed this (D05,D12,D13), but extended the list to traumatology (D06), anaesthesiology and intensive care (D03,D17,D25,D27) neonatology (D03), dialysis (D04) and paediatrics (D03,D17,D31). These areas provide insight into the motivation issue in two ways; first because of the general lack of informal payments but second because of what can be learned from those few cases where patients did attempt to pay.

Paediatrics and, especially, neonatology, illustrate the unsustainability of the 'donation' explanation. It is very unlikely that the apparent 'parsimony' of parents in these cases stems from lack of gratitude, especially in light of the circumstances that accompanies birth. This is a puzzling contradiction, as one of the physicians put it:

"R: ...and one more strange thing, which I'm not able to comprehend. If there's a problem with a child, there's nothing given in most cases..."

I: And why is this?

R: I don't know. I myself couldn't figure it out either. Because if I think it over, if I had a problem, or my child had a problem ...I'd pay first for my child, and not for me. But strangely enough this difference exists in relation to the paediatrician and the obstetrician, too. Paediatricians are rarely given anything after the delivery." (D17)

'Paying' and 'non-paying' services within the same speciality

This contradiction exists not just between specialties, but within a particular speciality, for which our research has provided an example from traumatology:

"I had an interesting case, a patient, who was brought in in a very serious condition; he'd suffered several serious injuries. Finally, he recovered, but didn't give anything. He came back years later, and asked me to operate his crooked toe. And for that operation he paid." (D06)

If willingness to pay really increases with the severity of the illness and the complexity of the required therapy, then why do injured patients pay the doctor only occasionally, and why is the urge much stronger in connection with even a relatively small elective procedure? And why is that that the few cases who do make informal payments to specialists in these areas are apparently motivated not by gratitude? This

can be inferred because they give in advance or when dissatisfied. For instance, a physician, in one of the aforementioned specialities, recalls her experiences with informal payment as follows:

"I'd say that rather those patients give, who aren't treated the way, as we usually do. For instance they have to wait longer, or if I'm in a bad mood, and they can sense this in my voice." (D05, also D06; and D03,D26,D31)

Differences regarding the same service: Home visits, choice of doctor, rank of physician and good work

The most obvious case against the 'donation' explanation, is that payment for the same service can depend on who provides the service and where it is provided. The interviews confirmed the difference between home visits and treatment in the surgery in the primary care setting (D20,D22,P13,P14), as discussed before, but also identified as important the choice of doctor (D04,D16,P01,P02,P03,P06,P07,P08,P09,P11,P12,P14, P15,P19), his/her rank and position (D17,D18,P06,P07,P10) and other aspects of the service, such as the number of patient-doctor encounters (D17,P02,P12; and P05,P11). As we will see, these suggest a radically different interpretation of gratitude.

What is common to these cases is that the difference between payment and non-payment cannot easily be explained by the extent of gratitude, because the content of the service is essentially the same. For instance, why should a patient be more grateful to be operated on by a senior consultant and not a junior doctor, as long as the outcome was equally successful in both cases?

Choosing a doctor

It is clear that the status of the physician is something that patients do consider when deciding how much to give. As a 59-year old woman recalled:

"...I found the doctor, well, not a low rank, but I got frightened, I almost fell over, when it turned out that the person, who was recommended to me was ...some kind of a director. Oh my God, they could have recommended me an ordinary doctor for ...if you ask somebody on a private basis, then obviously something is due." (P07; also P02,P06,P09, and D17,D18)

This is a good illustration of how the ability to choose a doctor is regarded as an 'extra' or private service, which must be paid for:

"...He [the physician] was very busy, and as I could see, there the others were 'private' patients, said to be private, but not private in reality ...patients belong to

a doctor, and they remunerate this some way or another." (63-year old female, P14; also P19 (cited previously), and P06,P08,P09,P11,P12,P15)

It seems that this is so strongly embedded in the system that doctors virtually expect to receive an informal payment, even if it is not paid in advance, and patients simply cannot imagine that it is possible to see a doctor without payment. For instance, a 46-year old woman with a chronic illness, who would rather go to one particular doctor for regular check-ups but has not asked for this so far, explains her reasons for inaction as follows:

I: But do you see a possibility for asking such a thing?...

R: First, it's the question of dare, too, but in my opinion the other thing is that if I can afford it then it would be possible ...If I had enough money to return to the same doctor, then I'd visit him for the monthly check-up at the ward." (P11; also P05 – did not dare to ask to stay in hospital for the weekend without paying the senior consultant)

From the doctors' perspective, those patients who do not pay the doctor may eventually be asked to 'leave':

"...if somebody visits ...a popular doctor two or three times without paying, for the fourth time the doctor says, 'then maybe you should find somebody else'." (D18)

Yet patients may find that this interpretation of 'choice' is forced upon them:

"R: ...I'd say, you know a lot of doctors almost about their tariff. Well ...if you go to the hospital one day before the operation, they're [patients] asking, who do you come to, ...who is your doctor?"

[the wife of the respondent continues] *They aren't asking that, but 'do you have a doctor'? I say no. ...Once I had a small operation ...and I was in for two days, three days, and I started to be browned off, and they did the morning rounds ...well, I said, 'I'd like somebody to examine me and I'd like to get over with it'. 'And who's your doctor?' 'Well', I said, 'sorry but I don't have a doctor' ... 'Well, if you don't have a doctor then you won't be operated.' They did the operation on the fourth day, ...when I got a doctor. ...But if I say to him that 'would you please', it's obviously accompanied with this [rubbing her fingers]...*

I: That means, you have to pay?

R: You have to tip." (wife of 63-year old man, P15)

This is by no means a language of gratitude. Patients talk about 'hiring a doctor', or a 'hired doctor' (P07,P12,P14,P20), and physicians about 'extra services' for which payments are 'due' (D21,D24,D28,D29). All these suggest an unspoken agreement

between patients and doctors that choice of physician is not part of the official benefit package. Patients who choose and then pay a doctor become 'private' patients in the public system (P07,P14), or as one of the physicians put it:

"...The other case, is when the physician thinks that s/he's provided a service and in return for this, s/he expects the patient to pay. These are the 'voluntary' patients..." (D24),

while the rest remain 'ordinary', 'normal', 'publicly funded', or 'drifting':

"...He was a young man, and I asked him, ...hadn't he asked anybody, and ...he told me that he hadn't, he let himself drift..." (53-year old woman, P17)

But why is the choice of physician so important? Why do patients think that they must pay if they want the doctor of their choice? Why do they think that not to do so means drifting in the system? And why do doctors expect that patients will pay for this? As a doctor put it:

"...I have a friend, who's expecting a baby, and I asked her whom she goes to. Because, ...I think that it's absolutely normal that you'd like to belong to somebody, especially in a situation like this. And she told me, that, well, nobody, because they cannot afford it." (D04)

This is indeed a legitimate question, since, according to the current legal situation, patients are entitled to choose their doctor freely within the particular tier of the system [1,8]. This implies that either they are not aware of their entitlements (which is possible, because during the communist regime there was, at least in principle, a strict referral system in place with no choice for individual patients), or there is something more important behind the act of choice. Our interviews suggest that this is a complex issue, and both factors play a role.

Obstetrics and gynaecology is the specialty where the link between the choice of the doctor and 'extra' services is most obvious. Because it is not possible to predict the exact time of the delivery, the child can arrive at any time, outside normal hours, during weekends, or while the doctor is on holiday. Doctors are not obliged to attend if they are not on duty, so if a mother insists on having a particular obstetrician to assist the delivery the doctor must sacrifice his/her free time, something that may be considered an extra service outside the public system. This forms the basis of the expectation by the physician that this must be paid for:

"...I'd say that it's very rough on me, if I come for a delivery during the night, and after that she says 'thank you, I'll see you sometime', ...that's very annoying

...this isn't a gratitude payment anymore, since ...I shouldn't be considered a fool that I come back from XY just for this [for nothing]." (D18; also D16,D24)

Yet there are other services whose 'extra' or 'private' nature is not so obvious, for instance a telephone call during the night about a trivial problem:

"...it's 10 p.m. and she says, sorry, but I haven't had stool for two days, what shall I do? Well, what can I say to this at home at the other end of the line..." (D19),

or when the patient goes to the hospital for an outpatient visit, instead of going to the official surgery at the polyclinic:

"...there's a patient, looking for you, that she's the patient of XY doctor, and she comes here in the hospital, and although I should be at three other places, I find some time to examine her ...and then she says thank you and goes away. Because it's quite different if she comes to the polyclinic, or another surgery, where I'm there [to see outpatients] ...then I don't expect her to pay." (D18)

In the latter case the border between public and private is not so clear cut and the assessment by physicians of what should be considered 'extra' does not necessarily coincide with official entitlements. For instance, if the child is born during normal working hours then no 'extra' service has to be provided, and yet:

*"...If I assist the delivery during work time, and I expect the money as I do at 2 a.m. – this is a question. Because during that morning I could have sat in my room without a lot of stress, and you feel, that you're entitled to it if the state doesn't provide it...
...if the patient insists to have doctor X to assist the delivery, or doctor X to operate on him/her, then ...this is his/her request, an extra service..."* (D24; also D16,D18)

Visiting a patient at home

Home visits in primary care are also examples of 'extra' services but, because it is more difficult to determine the degree of entitlement, the border is even more blurred providing scope for individual discretion. In general, family doctors and paediatricians are required to visit patients at home on request if there is a clinical need. However it is possible to envisage circumstances in which a patient would request the doctor to call just because s/he does not want to go to the surgery:

"R: ...usually we don't go to the family paediatrician, but he visits us at home, if I ask him. ...I think such a visit costs 800 forints..."

I: But does he tell you that...?

R: He tells us, ...when she got immunization ...we didn't go either, but he came, in the case of immunization it is 700 forints, in case of other illnesses 800.

...R: And does this physician have a private surgery?

I: A 'surgery by car', I'd say, because he doesn't have a private surgery." (29-year old woman, P13)

Working conscientiously

While there are some 'private' services that patients are not entitled to officially, such as access to physicians outside normal hours, patients may choose a doctor to secure services, which patients are clearly entitled to, at least according to the official benefit package:

"R: For instance, when I had my first pregnancy, I thought that ...the physician on duty, would assist the delivery ...With the second one, however, there were problems during the pregnancy, then I felt that I cannot trust [the doctor, who would happen to be on duty], I cannot risk ...the health of my child and mine because there was a problem during the pregnancy.

I: Then you had to ask [choose] a doctor [in advance]?

R: Yes, it was necessary." (46-year old woman, P11)

This suggests that 'going public', i.e. without asking a physician in advance, involves a perceived risk of not getting adequate care, something that should not be considered as 'extra', above that to which one is entitled. A similar impression is gained from other cases where respondents justify payments because of things that should be part of the standard service:

"...usually the stitches are removed on the fifth or sixth day, the decision [to pay] is based on how many times the doctor saw you during these days ...generally the more attention the doctor pays to you, the more you want to be grateful." (41-year old woman, P12; also P02,P09; and D17)

Further, respondents contrast the good experience with previous bad experiences.

"...I am grateful [to a dentist] as s/he gave me an anaesthetic ...once before my tooth was extracted [without anaesthetic], and I felt as if my brain was extracted..." (46-year old woman, P11, and two similar cases; and P10,P14)

Interestingly, in two of these quotations the descriptions used the language of gratitude, suggesting that a lack of attention was the norm and diligence was something 'extra' to be grateful for, albeit in a radically different sense from what the 'donation'

hypothesis implies. Such assessments are not at all surprising, in light of the performance failures discussed earlier.

Reassessment of entitlement

This is a good example that the definition of 'extra' when taken beyond home visits or choice of physician is even less straightforward. For instance, how many times should a patient be visited in the ward by a doctor? Or what is the minimum level of kindness and attention that is due? Entitlements are especially unclear to patients in a system that provides strikingly uneven quality of care, as a 47-year old patient put it:

"R: ...Look, if I provide an extra service I expect extra payment for it. This is straightforward, this is legitimate, this is a basic thing. But if I don't expect the senior consultant to visit me in the ward, only if s/he must do it? Morning rounds, afternoon rounds, etc, etc, but do it properly, so it shouldn't be that if I didn't pay, s/he just enters the ward and ...don't even ask me, how are you ...this is why s/he is paid for ...Now then if I expect the senior consultant to come in after work hours and provide me this and that ...a single room, special medicines ...then I should pay for it, because it isn't part of the basic service..."

I: ...Do you know, what can somebody expect, and what is above that...?

R: Well, maybe there isn't enough information, although it's displayed in hospitals, the time of the morning rounds, and when...

[his wife interrupts him] ...Well it is, but not the money..." (P20)

On the other hand, even if entitlements were clear, patients confront the failure of the system to deliver these entitlements, either in their own experience or that of relatives and friends. They reassess what they can realistically expect from the system. As a result, the normal can become the 'extra' to patients, but also to doctors, who think that they have a legitimate basis to accept payments, because the state does not provide a fair salary:

"...I think that primarily there are abuses in these two areas [obstetrics and surgery] ...But surely the official salary is an abuse ...with my experience in two specialties, I take home between 60-70,000 forints⁵³ per month..." (D04; also D09,D10,D13,D14,D20,D22,D23,D24,D26,D28)

It is not surprising then that certain physicians think that they 'deserve' informal payments, or even they are 'entitled' to them, because they 'laboured for' them so that they are justified in case of any good performance (D18,D19,D20,D24,D28,D29). On the other hand this link between performance and payments establishes some sort of

'proportionality' in terms of the amount that is 'due', and this works in both direction: if a surprisingly high (D18,D21), or a disappointingly low amount is given:

"...and then ...she gives 5000 forints, and ...I think that I have earned 5000 forints over X months. I understand that patients don't have enough money, ...but they have money for a refrigerator or a colour TV." (D18)

If the outcome of this process of reinterpretation of entitlements coincides in the minds of most patients and physicians then a new, unwritten set of entitlements emerges, which makes the time of giving immaterial since patients know that they have to give, and physician know that they will get it. Choice of physician and receiving home visits can be regarded as such new entitlements, offering a plausible explanation for some of the differences observed in the distribution of informal payments. For instance, in traumatology the circumstances do not allow the patient to choose the surgeon in advance, but if the traumatologist performs an elective orthopaedic operation, informal payments work as in other surgical specialties. The same applies to anaesthesiology and intensive therapy ('no choice, no obligation'), although the situation with paediatrics is less clear in relation to choice.

Nevertheless, the establishment of these 'points of crystallisation' in a 'fluid' system do not require that everybody agrees. For instance, some physicians noted that there is the so-called 'self-conscious' type of patient:

"...when you visit a patient in the wealthy quarter of the city, you cannot be certain [that you will receive informal payments], because s/he's self-conscious, and s/he knows that s/he's entitled to it, while if you go to another place, where a simple, elderly family lives, there you can be almost 100% sure ...that you'll get something." (D20; also D22,D23)

At the other extreme, there is the patient who feels that without informal payments the doctor does a favour for him/her:

"...[when I offered informal payment] almost every doctor said no. And I told them that ...I am a poor woman, but I don't want to accept charity [treated like a pauper]..." (P05)

From the doctors' perspective, the spectrum is equally wide from those who categorically refuse payments to those who explicitly demand them, even specifying the amount required:

⁵³ €240-280.

"...there's a child in the family, who ...needs operations frequently, and allegedly they have to give 60,000 forints to the professor to do the operation..." (63-year old woman, P14)

But if doctors' and patients' reinterpretation of entitlements does not coincide, doctors are in a position to impose their expectations on patients.

8.3.1.3. Direct coercion: pressures from providers and other patients

The most obvious type of coercion, which is inherently inconsistent with the gratitude payment concept, is when the pressure to pay comes directly from the providers. However, this pressure seems rarely to be as overt as in the cited example, when payment was demanded upfront as a prerequisite of the operation (P14; also P06,P20), or when insufficient informal payment is offered and the doctor refuses it:

"...there was a woman, who was crying in the waiting room, and ...she told me that she put a 5,000 note in the envelope, and the senior consultant ...looked at it and gave it back saying 'I'm not living on wafer'." (60-year old man, P18; also P09 cited before, and P01; and D18,D29)

The range of more 'subtle' mechanisms used to extract informal payments is very wide, from denying or delaying care to frequent visits and enquiries about how the patient feels, to simply being in the right place at the right time. Their applicability depends on the circumstances applying to each specialty (P02,P05,P06,P08,P10,P11, P13,P14,P15, D17,D24,D25,D30). For instance, in surgical specialties it is possible to manipulate the order of operations so that patients who do not pay somehow find themselves at the end of the list:

I: And how do you think this favouritism is manifested ...?

R: Well, the drugs are the same obviously it's rather manifest in the circumstances. ...Who will be the first on the list of operations, or who will be the last, which, you know in advance, will be cancelled anyway ...and ...postponed to next day. Now then next day he won't be the first either, but the last again, well ...nobody strains himself for a 'non-paying' patient.

I: Aha, but sooner or later he'll be operated won't he...

R: Well, sooner or later, if he's lucky, eventually he'll get on the list somehow, or if the penny dropped, or if ...the patients discuss it in the ward..." (D17),

and a 63-year old patient recalls his experiences as follows:

"...I was in the hospital, they did an X-ray, looked at it and told me that it had to be operated on ...and I asked the doctor to do the operation. But, then, he told me we have to discuss this. I visited him three times to discuss it, in the afternoon, in

the morning ...and he visited me 9 p.m, and visited me another time, but he still hadn't operated on my arm. Well, I said to myself ...what should I do, ...it was emergency case, but the operation was postponed. Then next day ...I told my wife, please bring me 5,000 forints ...the following day my wife brought the money, I put the envelope into his pocket in the evening, and next morning 9 a.m. I was in the operating theatre." (P15)

We have already discussed the significance of frequent patient-doctor encounters (P02,P12,P15,P17,D17), particularly if they have 'no' purpose, other than to enquire about the general state of health of the patient:

"...And while I was recovering he visited me at least three times, I went out to the toilet and he was coming towards me, how're you Mr. X, how do you feel Mr. X, and so on, well, I said to myself, I bet he's expecting money. I went to my bed, and half an hour he was there again. Well, what shall I do ...I had 2,000 forints on me and put it into his pocket." (63-year old man, P15)

In other cases hanging around the patient is a tool to make the connection between 'delays' and their 'solutions':

"...and when the child was about to be discharged ...everybody else received the medical report. The doctor was coming and going, and I asked him two or three times, how long we have to wait. It'll be ready in a minute ...but eventually we received it sometime in the afternoon. And I felt that he was hanging around waiting for me to put the envelope into his pocket" (46-year old woman about her son's case, P11),

a phenomenon also reported in primary care:

"...when the treatment was over, ...the [family] doctor walked to the windows, and stayed there looking through it at the street. And I remember telling to my husband ...to give him/her money. The minute he gave it to the doctor, s/he left right away." (68-year old woman, P10)

Ward-rounds also provide an opportunity to make patients understand what they have to do:

"I've seen such ward-rounds, when those, who didn't pay were skipped. Well, these are really disgusting things." (D30)

If these signals are not enough, a private conversation in the doctors' study (which in Hungarian hospitals can usually be found attached to the wards) can 'help'. The interviews have revealed that patients attach a special significance to being invited there as it is associated with informal payments:

"I've heard about a doctor who liked wondering around the corridor in visiting hours in a white coat with deep pockets, and once I was also in a situation, when ...the doctor came to me on a Saturday morning and said that I could go home ...but ...I had no transport, no escort and nobody was at home. And then I told to my doctor, I cannot go home, where shall I go? And s/he told me to speak with the senior registrar. And I said no, ...I won't take the senior registrar an envelope just because s/he gave me a smile at my bed three times a week. If you pay a visit then you have to take the envelope..." (54-year old women, P05)

Then there are gestures (opening the pocket) and hints (for instance about the cost of care, the innovation of the treatment) to draw the patients' attention to what they should do:

"We were called in, the senior registrar made us sit down, we were quite frightened. And s/he told us, that look madam, here things work with thick envelopes..." (52-year old woman, P06; also P10,P16),

and

"...I'll never forget that she [the doctor] opened the pocket of her white coat, to [put it in] there, then. She did so, although I didn't show any sign that I'd give any money to her. It was so obvious what she was after, and I think I would have felt so embarrassed if I hadn't had anything to put in there. The other side of the story, of course, are patients who ask after the operation, how much did you give ...I was astonished ...and my husband ...told me that we didn't have so much money. I think one is pressurized from both sides, patients as well as doctors." (33-year old woman, P08)

This latter example is good illustration of the point that patients themselves can also be a source of coercion (P02,P04,P05,P08,P11,P13,P15,P16,D18), and maybe a vehicle for doctors to set their 'fees'. Nonetheless, the relationship between patients and between patients and doctors is radically different, because of the imbalance of power which, as we saw, makes it especially difficult for patients to resist pressure from physicians:

"...The patient, who visits me with a bunch of flowers a week after, because I provided him/her detailed information [about his/her illness], is really grateful, because s/he was absolutely not exposed to me [not in my hands /not at my mercy] ...but I think patients pay, because they felt obliged to do it. This is just a masking that they'd give anyway, and they're grateful and so on, certainly they'd give, but they feel that they have to give" (D11),

and

"R: ...but maybe if I met an ill-mannered doctor, but who works well, I gave it [informal payment] to him/her as well.

I: That is, if the results show that you recovered?

R: Yes, if the outcome is good. But, unfortunately, because one is a little bit defenceless [exposed], one would give it even if the results aren't good, ...if one has to go to hospital." (63-year old woman, P14)

The 'art' of eliciting informal payments

Given that provider coercion is associated with the behaviour of doctors, there are certain skills that can be learnt and practiced, as one of the doctors revealed:

"...After a while I felt that if I drove harder I could earn more. ...when one is increasingly immersed in a situation, ...begins to feel the patterns which make it work ...the Pavlov-reflex, in its real sense, when one responds ...to the smell of money and feels the manners, the techniques, with which gratitude payments can be elicited." (D03; also D01,D02,D04,D21,D25, D29)

All these suggest that enforcement of informal payments can be a 'profitable business', if one decides to set out on this route:

"...As long as you'd like to buy not just nappies, but something else for your child ...you'd try to find ways how to make more money. And from this point on it's the question of how far, given his/her own value system and norms, one will go. There are those, who say to the patient, madam, one visit will cost you 4,000 forints. S/he's no right to say it because s/he works in a public hospital, but there are such persons out there." (D29),

but on the other hand it is very difficult not to make patients appreciate the bad circumstances:

"...it's overcrowded, enormous mass of people, you're sweating, lots of night duties. The official salary is outrageously low, practically you cannot make ends meet. The consequence of this is that sooner or later you get exhausted, distorted, and the patient-doctor relationship suffers a lot..." (D30),

and once doctors accept informal payments it may not be easy to draw the line between what should and should not be accepted:

"...in the beginning I had my rules about whom I didn't want to accept money from, the elderly, the terminally ill, and so on. And after a while this circle is contracting somehow, ...as it's not easy to refuse it, because it's ...difficult to pick and choose among patients. I rather think that there are two ends of the

spectrum. The ones who virtually never accept it, and the others who accept everything with no exceptions..." (D02),

and a justification is always at hand:

"...I believe that many find peace of mind in giving in advance, because they feel that the whole thing secured, then why should I deny them this feeling, after all they designated the money for this purpose anyway." (D11)

Nevertheless, as we will see, even doctors, who categorically refuse informal payment, can get into a situation where they incite it, even if they have no such intention.

8.3.1.4. Coercion as misinterpretation of conventional situations: A new understanding of gratitude

The 'art' of eliciting informal payment can sensitise patients to perceive the signals of 'expectation', and may create a view that doctors usually 'expect' it (P07,P08,P10, P11,P15,P19). However, this has the potential consequence that patients misread behavioural 'clues' and pay even if there is no such intention by the doctor. For instance, we previously quoted the example of a physician in a 'non-paying' specialty who experienced that the rare occasions when informal payments are made tend to be associated with being less nice to patients, when s/he happens to have a bad day; reflecting on this she adds:

"To be honest, I really felt bad about this afterwards, because I didn't have any intention whatsoever to squeeze gratitude payments from the patient." (D05)

Given that most of these behavioural 'techniques' are in fact an integral part of a normal patient-doctor relationship and, as discussed previously, poor system performance mean that low standards are common, good performance can also give rise to unintentional coercion. We have already cited examples of how typical patient-doctor encounters, especially when conveying a diligent, conscientious attitude can be regarded as something 'extra' to be paid for. In a context where such signs are perceived as suggesting an expectation to pay, doctors who have no intention to send such signals, but simply to do their job properly, may feel embarrassed in or even try to avoid behaviour which is simply doing their job properly (D22,D27):

"...I was always embarrassed by gratitude payment, so much, that, well, you know, many people ...ask me, such as the elderly, to check their blood pressure, to visit them at home regularly, once in a month ...and I always say no, sorry, not this way, but if you call me I'll visit you the same day, but I don't make such

agreements ...first, because this way you seal an invisible contract ...that because I come, they've to pay. Second, if they cannot afford to pay anymore, but don't dare to tell it ...I don't want to drag them into an embarrassing situation. And I still say ...that what they ask for should be the job of the family doctor, but I don't dare to do it",

and

"...it's often said that you should visit the patient on the day of the operation. You should see him/her professionally [for medical reasons], and not to open his/her bedside table – well this is incredible, this is a joke – whether there's anything there, but we must be glad that the patient is all right ...and then either you don't go to the ward, or it's so humiliating, because it isn't that I want money ...I came here, well what did I come for?"

In this context genuine good work is interwoven with work fuelled by expectations and it becomes increasingly difficult, or impossible, to distinguish the two. Ultimately, how the situation is understood depends on the perception of the patient:

I: And what did you experience in general, ...did they accept what you offered?

R: They always accepted, and of course they expect it.

I: And can you tell that the doctors or nurses actually expect it, does it show?

R: Of course.

I: And how is this manifested?

R: How? I cannot tell you, somehow it's written on their face. One or two kind sentences, or visiting me couple of times in the ward and things like this, and then you feel that you must pay, just because the doctor came to see you more than s/he did the old lady next to you." (52-year old woman, P02)

Given that entitlements are unclear, the number of visits or kind words considered as either an 'extra' service (as discussed before, e.g. P12,P14,D05), or signals to induce informal payments, is down to individual interpretations by both the patient and the doctor. On this basis we argue for a new understanding of gratitude, which is very different from the one that the 'donation' explanation is built on.

In a health care system that fails to perform adequately, good work achieves a new meaning in that either patients' expectations are exceeded or patients perceive this as a prompt for informal payments. It may not be easy to separate the two because they depend both on the intention of doctors and the perception of the patients, but this distinction is less important inasmuch as both contradict the donation explanation of informal payments. The essential difference between the 'I got more than I expected' approach to gratitude is that good performance is not valued in itself as with 'genuine'

gratitude, but instead in comparison with the low standard of service that might have been received. The coercive nature of the former is further enhanced by the 'I got more, because the doctor would like me to pay (or would be disappointed if I did not pay)' approach, with which it is intertwined, indicating the subtleties of coercion in real life:

"...I give occasionally, because I may create a feeling in the doctor that 'did I do something wrong that s/he doesn't give me gratitude payment?', that is 's/he isn't satisfied with me' and I induce a feeling of remorse in him/her, although maybe s/he'd be glad that s/he doesn't have to be in a relationship with me that I paid him. So, it's a rather complicated thing, so if it's possible we've to get rid of it as soon as possible." (63-year old woman, P14)

8.3.1.5. Coercion by patients

So far the discussion on the 'coercion factor' has focussed on that patients are defenceless in the system where they are subject to the whim of doctors. We have implicitly assumed that informal payment does not serve any purpose other than a general expectation that doctors should do their best. However, our interviews revealed that there are cases in which informal payment is a means of patients to 'control' doctors. In certain situations patients consider informal payments more like a contractual relationship (D04,D28), in which the expectations contained in the unwritten agreement are more clearly specified, either in terms of the immediate service obtained (D03,D04,P19) or the expectation that it will extend into the future (D01,D02,D13,P14).

These include situations in which patients want sickness leave or disability certificate, to keep their grandmother in hospital, or want a specific diagnostic service:

"...and the man comes in extending his hand forward with money in it ...and he asks me whether I can do an ultrasound examination of his heart. And I said no, because such cases always upset me ...I do think it's upsetting, if someone thinks that my professional judgement ...to refer to somebody for an examination can be bought like a litre of milk in the supermarket." (D03),

or patients can pay the doctor informally to create an obligation which allows patients to call the doctor any time in the future:

"...when you take the money, then actually you take on some sort of ...obligation, ...a guarantee ...for the service. ...the patient ...gives you the money, and then after two months ...s/he calls you ...and then a sort of 'surgery' begins, that, well doctor, I need this and I need that. And in this case, it's very difficult to say no. There were these occasions, when I felt I was bought." (D02)

Apart from the obvious contradiction of the 'donation' hypothesis, the latter example highlights an important aspect of the 'coercion factor' that goes beyond the actual event. It reinforces the point that the informal payments cannot be understood in isolation from past experiences and expectations for the future.

8.3.1.6. Coercion and other circumstantial evidence

Besides these manifestations of the 'coercion factor', there is circumstantial evidence not directly related to coercion and the motivation for payments, but which indirectly provides information about the validity of the gratitude payment concept. By means of the interviews we have explored four different areas: (1) the method of determining the sums, (2) opinions of respondents about the reasons for giving, in general, (3) attitudes towards informal payments, and (4) timing of the payment.

This analysis revealed a wide variety of external influences on patients concerning how much they will give. These external influences create pressure on patients inasmuch as the amount is not determined solely by the ability to pay, thereby contradicting the 'donation' explanation that envisages informal payments as a spontaneous act of gratitude.

We have previously discussed the most explicit form of 'price-setting', i.e. when the doctor directly tells the patient the amount expected, or drop hints, or behaves in certain ways such as refusing small amounts until the patient eventually gets the message of how much is expected (P01,P05,P06,P09,P18,D18,D29). Nonetheless this is not the only way in which doctors may contribute to 'price-setting'. Some of the doctors reported how they are often approached by family members enquiring about how much to pay (D03,D04,D09), and one doctor was asked by patients whom s/he referred to the hospital (D29).

Nevertheless, fellow-patients seem to be the most important source of information (P01,P02,P03,P04,P05,P07,P08,P10,P11,P12,P13,P15,P16,P17,P19,P20,D10,D24,D29,D31) although with some evidence that they overstate what they gave or will give (P03,P08,P10,P16), and that they are competing, thereby pushing up 'prices' (P02,P04,P08,P13). Relatives and friends also play a part (P01,P09,D10), creating an informal consensus (P02,P07,P11,P20), with 'price lists' or 'list of tariffs' (fees) occasionally hitting the local or national media (P05,P12,P17,D16). It is not clear how much these pressures eventually influence the amount that the patient gives, but our interviews create an impression that they provide an important framework for payments.

The attitudes of patients towards and their beliefs about the reasons for informal payments also contribute to the framework within which payments take place. There are respondents who explicitly condemn the practice of informal payments and would like to see them eliminated from the system (P03,P07,P08,P10,P14,P16). This suggests that there must be some form of pressure on patients to pay, as it is unlikely that somebody does something voluntarily that s/he disapprove of. Further, our interviews revealed conflicts between motivation captured by the survey, opinions revealed on in-depth questioning of respondents, and other evidence about the motivation underlying the events:

"...my motivation is that I'm grateful and this is how I can express it and I give. You can really think about this, but I'm convinced that with much better salaries they wouldn't expect it. And it's very rare that they don't accept it." (P07; also P08,P09,P10,P12,P13,P14,P15,P17)

This does not mean that patients are confused about their intentions but rather that the survey questionnaire inevitably oversimplifies the complexity of the decision to pay.

The interviews also revealed that equating the time of making the decision to pay with the time of the payment can be misleading, so that the fact that the payment was given after the service was received does not say anything about the motivation of the patient. For instance, patients can prepare the 'envelope' in advance, even if they give it after treatment (P02,P11), or may make the decision beforehand without knowing what the outcome of the medical intervention will be (P09,P19). In certain cases the patient may even drop hints about the intention to pay:

"...there's a more subtle form, when there's a verbal hint from the patient, such as 'do everything what you can and I won't be ungrateful', or that 'I'll thank you'" (D04),

although not all such hints imply a true intention to pay; this could be a strategy for those who do not want or cannot afford to pay, yet would like to secure the perceived benefits associated with informal payments:

"...and there are patients who say that 'I'll come and see you, doctor', and you know right away that they won't come." (D18; also D06,D21,D25)

8.3.2. CONCLUSIONS: GRATITUDE, CUSTOM AND THE 'COERCION FACTOR'

So far we have explored the various manifestations of the 'coercion factor' by means of interviews with patients and doctors. In this section we summarise evidence relating to

the 'coercion factor' from the in-depth interviews in those cases where we identified exclusively 'non-coercive' reasons for giving in the survey used in the Kecskemét 2001 study, but first we briefly summarise our findings about what forms the 'coercion factor' can take.

The in-depth interviews revealed how past experiences with the health care system, or with informal payment itself, can shape the decision to pay. Experiences such as a lack of hygiene, inadequate supplies, provider negligence, misdiagnosis or malpractice can create distrust that the system will deliver acceptable care, and at its extreme they can lead to a view that 'it is not possible to receive adequate care without payment'. Nevertheless one does not have to reach this point to feel that payment is necessary. Even if experience of the benefits that can be obtained through informal payments is mixed, non-payment can increase the natural anxiety that accompanies health care interventions by creating a concern that 'I have not done everything', that can only be overcome by informal payment.

On the other hand, payment patterns suggest that the 'coercion factor' works selectively insofar as patients do not pay for each service they utilise. Yet these patterns cannot be explained by the 'donation' hypothesis, especially when it comes to the 'non-medical' content of a service, such as choice of doctor, setting, position of the doctor, intensity of treatment, and so on. The interviews suggest that these are part of an emerging consensus on new entitlements, either as a result of a lack of clarity about official entitlements or a failing system unable to deliver them.

Both patients and doctors individually reassess official entitlements. Patients consider what the system will deliver without payment, while doctors consider what can fairly be expected of them in return for an unsatisfactory salary, with what is beyond that being defined as 'extra' services for which payments are expected. If these reassessments coincide, at least for the majority of doctors and patients, the new entitlements became established, as is the case with choice of doctor. In these circumstances, the standard of performance that should be expected can become an 'extra' service simply because of the contrast with the unsatisfactory performance that patients anticipate they will receive.

Where the views of patients and doctors do not coincide, doctors can impose their expectations on patients by enforcing informal payments. We have explored the various means of direct coercion and concluded that their deployment can sensitise patients leading to the view that 'doctors generally expect informal payments'. In these

circumstances otherwise normal behaviour may be interpreted by patients as a prompt for payment.

Given the observation that good job can be perceived as 'extra' service ('I have received more than I anticipated'), as well as unintentional expectation ('I have received more, because the doctor wants me to pay') we can identify a new, 'coercive' interpretation of gratitude ('I am grateful, because I was not treated negligently, and I have to pay the doctor, because he would be disappointed if I did not reward his/her performance'), which is different from how it is seen in the 'donation' hypothesis ('I am grateful because the doctor restored my health').

Although doctors are a stronger position to impose their will on patients, informal payments can reverse the balance of power. Patients can see informal payments as an invisible contract allowing them to specify the service they will receive, thus constraining the doctors' professional autonomy. Creating an obligation for future services ('I paid ('bought') the doctor so I can call him any time in the future') illustrates this type of coercion by patients.

Finally, we explored some circumstantial evidence related indirectly to the 'coercion factor', including external pressures to determine the amount of informal payments, attitudes towards informal payments (negative attitudes are incompatible with the 'donation' explanation), the discrepancy between views about motivation for informal payments in general and the revealed motivation in specific circumstances, and the discrepancy between the time of making the decision to pay and actually paying.

In summary we have identified five main areas that manifest the 'coercion factor' (distrust, extra services, direct coercion by providers, misinterpretation of conventional situations, coercion by patients) and explored four areas of circumstantial evidence ('price-setting', attitudes, general opinion on motivation, timing of payment). On the basis of these we have reviewed the interviews with patients who stated in the survey that they gave for 'non-coercive' reasons, to try to identify any 'coercion factors' in the encounters described.

Table 8.6 summarises our findings, which show that there were at least 3 manifestations of coercion in all 11 cases,⁵⁴ providing evidence that surveys are unreliable tools to capture motivation for informal payments.

⁵⁴ It must be noted, however, that we have added up the detected manifestations of the 'coercion factor' for the ease of presentation only. The absolute number does not indicate the strength of incompatibility with (or contradiction to) the gratitude payment concept.

Table 8.6. The ‘coercion factor’ in informal payments of patients, who stated to pay because of ‘non-coercive’ reasons in the Kecskemét 2001 study, explored through in-depth follow-up interviews

	P07	P08	P09	P10	P11	P12	P13	P14	P15	P16	P17*
Coercion as distrust											
Past experiences with health care											
Lack of hygiene, supplies, negligence	+	+	+	+	+	+	+	+	+	+	?
Misdiagnosis, malpractice	+	+	+	+			+				
Past experiences with informal payments	+	+	+	+	+	+	+	+	+	+	
Actual experience with the service											
Lack of hygiene, etc.				+					+	+	
Misdiagnosis, malpractice										+	?
‘It is not possible to have adequate care without payment’											
‘I did everything’											+
Coercion as unclear entitlements and extra services											
Choice of doctor	+	+	+			+					+
Home visit							+	+			
Direct coercion											
By providers				+					+	+	
By patients											
‘Doctors expect informal payments’	+	+		+	+				+		
Coercion as misinterpretation											
New understanding of gratitude			+		+						
Subtotal	5	5	5	6	4	3	4	3	5	5	2
Circumstantial evidence											
External pressure on determining the amount							+			+	
Negative attitude	+	+		+				+		+	
Coercive reasons of giving in general (or actual case)	+	+	+	+		+	+	+	+		+
Payment has been decided in advance	+						+				
Subtotal	3	2	1	2	0	1	3	2	1	2	1
TOTAL	8	7	6	8	4	4	7	5	6	7	3

Note: +=detected in the interview; ?=cannot be determined for sure; *The interviewee numbers correspond with the numbering in Appendix B.

8.4. Pressure on physicians to accept informal payments

The next step is to extend analysis of the ‘coercion factor’ to physicians, to explore the pressures to accept informal payments. Although this will not directly address the validity of the gratitude payment concept, it contributes to understanding the ‘coercion factor’ in two respects.

First, acceptance of payments reinforces the view among patients that this is a normal thing to do:

“...we usually give to the family doctor, if we must call him/her to visit one of us,

or grandmother at home. For instance, if we cannot take her to the surgery, because she has high fever, then I give him 1,000 forints and s/he takes it, and never says that no, or something ...and because s/he takes it so naturally, then I think others do the same, because, for instance once the doctor on night duty came and then I asked him/her, how much do I owe you, doctor? ...Nothing and then I gave it to him/her and s/he took it. S/he [the family doctor] doesn't say anything, we don't ask anything, just pay. Well, probably we owe him/her that much." (63-year old woman, P14)

Second, in a context where giving is seen as natural, refusal to accept informal payment puzzles patients:

"...you feel, either in the eyes, or in the communication, you can sense some sort of doubt, ...then the patient gets embarrassed and you can see that suddenly, for a moment s/he gets frightened, why isn't it accepted? Does s/he look like so poor, or so seriously ill, or whatever" (D02),

and they can easily misunderstand it, even if the doctor only wants to show that it is not necessary:

"...I almost always had a bad feeling after I refused to accept it, because it didn't convey the message that I intended to convey, ...that you can receive decent care without payment." (D04)

Indeed, our interviews have revealed that patients can misread non-acceptance in several ways. We have already discussed how refusal can be a means of stating that not enough money was given, and patients may attribute this meaning to it even if it was not intended (D04). Other misinterpretations include the patient thinking s/he is terminally ill (D02), that they are considered too poor (D02,D04,D09), or the doctor does not consider the patient worthy enough (D04):

"...There are cases where you have to accept because the patient may feel that his/her money isn't valuable enough. For this, you need some empathy ...not to hurt them." (D23; also D03,D04,D21,D24)

Patients may even associate refusal with a low level of competence of the doctor, i.e. acceptance of informal payments becomes a surrogate for quality:

"...there's a very strong belief that a doctor who doesn't accept money is probably not so good ...there are those, ...who ...create a direct relationship between the quality of your work, the acceptance of informal payment and the amount you accept ...if I don't accept it, or my 'price' is low ...for him/her means the quality which s/he can expect from me." (D04)

Nonetheless, patients are not the only source of pressure on physicians to accept informal payments. Friends and relatives can be equally puzzled by non-acceptance and consider the doctor who has such a 'strange habit' as at least a bit 'touched':

"...I know somebody who never ever accepted it, well, s/he wasn't in need of it because s/he went abroad for a while and earned a lot, it was tolerated though [by his/her colleagues], if s/he's so silly that's the end of it" (D27),

and

"...I feel that my disapproval of informal payments has had an adverse effect on my reputation among my family. They acknowledge my integrity, that I'm an honest man, but something must be not quite right in my head." (D03; also D04)

Nevertheless, colleagues are not always so tolerant:

"...back to the colleagues ...if you're sussed out by them that this isn't so important for you, they don't talk to you that way, or they give up on you ...because I didn't have a clue why was it better to work in female wards. It turned out that it's because women pay more." (D04),

and s/he eventually finds himself/herself 'preferentially' treating 'non-paying' patients who may be less rewarding professionally:

"...if it's discernible that you never accept informal payments, then after a while you can experience negative effects. ...you'll get the worst cases, which gives you little professional satisfaction. The hospitalised geriatrics, the down-and-outs, who need primarily nursing care, with whom it's very difficult to cooperate, and so on." (D02)

These negative attitudes are even stronger where colleagues feel their 'business' is threatened by the 'deviant' doctor (D02,D05,D13), ultimately forcing the person to leave:

"...I had a friend who was removed because s/he didn't accept gratitude payment on moral grounds, and news spread that one didn't have to pay in that wards, and ...s/he was an excellent specialist loved very much by patients." (D05)

Finally, we have already discussed the pressure created to accept payments by the inadequacy of salaries, with many of the interviewees pointing out the injustice and immorality of a system that sets official salaries on the expectation that informal payments will be made (D04,D09,D20,D21,D23,D24,D29,D30) and then levies a tax on them, increasing pressure to accept (D24,D30). It can be seen how this situation will lead doctors to consider informal payments not as a gift but as something that is due and

even necessary to make ends meet. In settings where informal payment is insignificant, doctors must take up second jobs unless they have sufficient income from other sources, for instance their spouse or extended family (D03,D05).

Finally, there is also the characteristic of informal payment as a mark of being a qualified doctor:

"...and actually I didn't feel hurt, rather uplifted that I was considered to be a 'human being', a doctor, because they gave money to me." (D03)

Taken together, these factors create a society-wide pressure to accept informal payments:

"...this is so deeply embedded in the system and so important part of its functioning that I didn't see much chance to change it" (D04),

establishing a norm in which those who do not wish to accept informal payments are considered abnormal and are strongly pressurised to reconsider their decision:

"...then you say, that maybe there's something in your approach, well, I wouldn't say problem, but still, and then within certain limits, which are acceptable for you, you decide to take it. ...Because after all, you make your job more difficult [by refusing informal payments]..." (D04)

8.5. Conclusions

So how can we interpret our findings in relation to the 'donation' hypothesis of informal payments? First, although survey findings at first sight seemed to strengthen the case for this hypothesis, deeper analysis of the TÁRKI-1996 and Kecskemét 2001 studies revealed similar contradictions to those found in the review of the literature reported in chapter 4, further strengthening our suspicion that surveys do not accurately capture the motivation for informal payments.

Second, the analysis of in-depth interviews with patients and doctors provided insight into the many ways that coercion can be manifested in the patient-doctor relationship within the context of a health care system that fails to provide consistently adequate services. During the course of this analysis we have shown how 'non-coercive' reasons for giving often assume an interpretation that is very different from how they would be understood within the framework of the 'donation' explanation of informal payments. This suggests that there is not a general consensus on what

‘gratitude’ or ‘custom’ mean in this context, and although respondents to surveys select these options, their interpretation and that of the researcher may not correspond.

Third, the in-depth follow-up interviews with those citing exclusively ‘non-coercive’ reasons for informal payments revealed that, in none of the episodes recounted, did giving correspond to ‘non-coercive’ motivations as implied by the ‘donation’ explanation. Although caution is needed because of the small numbers involved, it is significant that we were able to identify at least some manifestations of coercion in every single case, further strengthening the case against surveys as appropriate tools to capture motivation of informal payments and the suspicion that their findings are misleading. Fourth, the analysis of interviews with physicians provided insights into the difficulty of refusing informal payments.

While all these findings suggest that informal payments take place in a context that is very far from the culture of gratitude envisaged by the ‘donation’ explanation, where it is virtually impossible to separate the acts of ‘genuine’ gratitude, if they exist at all, from those which are the results of coercion, we must not forget the limitations of the research, which have been discussed in chapter 5. Besides the general validity and reliability trade-off, it is important to consider how far the findings of the qualitative interviews apply to the country as a whole. In general, using the survey to identify cases offered a systematic sampling method, but it is limited by the choice of the study population. On the other hand non-responses may have been less of a problem in this respect, since for instance bad experiences (a cause of refusal to participate in the survey) are unlikely to be associated with non-coercive payment motives, and the same applies to respondent bias. Although recall bias could have been a problem, inasmuch as the responding person had to talk about the case of another member of the household, in all cases the interviewees talked about their own experiences, including those interviewees whose children had been ill.

Nevertheless, the private sector is a setting, where ‘real’ gratitude payment may occur and consequently may still provide some ground for the ‘donation’ explanation of the phenomenon.⁵⁵

⁵⁵ We have selected a private for-profit hospital as a case study for private sector informal payments, but this part of the study could not be incorporated into the main text because of space constraints. Nevertheless, the preliminary findings, which suggest that informal payments do exist in the private sector and the motivation for giving them is multifaceted, are presented in Appendix I.

CHAPTER 9.

9. THE MYTH OF GRATITUDE PAYMENT: SYNTHESIS AND RECOMMENDATIONS

In the previous two chapters we have summarised findings in two research areas, both related to the central theme of this thesis: the motivation underlying informal payments. While we have considered the implications of the evidence in relation to motivation at the end of each chapter, we have not yet considered these pieces of evidence together to assess the overall picture of this phenomenon that they present. In this concluding chapter we will not just summarise our findings as they apply to the research questions posed, but look at where they fit in relation to existing research on informal payment and what they say about appropriate policy responses in the context of the Hungarian health care system. In doing so we also outline some directions for future research, because an even deeper understanding of informal payments and the context in which they take place is a prerequisite for effective policies in this area. Nonetheless, before proceeding, we recall from chapter 3 the theoretical underpinnings that defined the overall framework of the study. We used the logic of this framework to determine the data to be collected and ultimately to make sense of the evidence obtained.

9.1. Methodological results

According to Silverman [242,p.233] a Ph.D. research can be theoretical, methodological and empirical. This thesis has all three elements, with a stronger emphasis on the theoretical and empirical aspects of informal payments. Its methodological contribution, that questionnaire surveys are unable adequately to assess motivation on their own, was less pronounced, but it still contributed to shedding light on the validity of the 'donation' hypothesis as an explanation of this phenomenon.

9.2. Theoretical results: the definition of informal payments and the theory of 'inxit'

In chapter 3 we examined the various forms of the phenomenon described as informal payment and confronted its distinctive features with the definitions (illegality, informality, corruption) proposed so far. We concluded that none of these definitions incorporates characteristics that are common to all forms of informal payments and at the same time are applicable across countries. Instead, we suggested an alternative based on the key distinctive feature that they are in fact additional payments, above

what is stipulated in the terms of entitlement. This new definition has implications for both research and policy making; for the operationalisation of informal payments and for understanding it, since it inevitably raises the question: why do people pay more than they have to?

Then, we reviewed the theoretical literature to identify answers that had been suggested to this question, summing up the debate as generating two contrasting hypotheses of informal payments: the 'donation' and the 'fee-for-service' hypotheses, each with very different implications for policy-making.

In chapter 1 we used a general policy-making framework put forward by Roberts et al. [53], in which they suggest that whether a particular phenomenon, such as informal payments is a problem ultimately depends on the objectives that the health care system would like to achieve. Examining the situation in Hungary, we concluded that, while there is no general agreement on the priorities among its objectives, at least there seems to be a consensus on what its objectives are, namely quality, efficiency and equity (equal access for equal needs). According to this approach, informal payment is not a problem in itself, but only if it adversely affect quality, efficiency and equity.

The importance of the two contrasting hypotheses of informal payments thus comes from their differing implications for these objectives of the Hungarian health care system. Compared with the 'fee-for service' hypothesis, which implies far reaching and generally adverse effects on both equity and efficiency, the 'donation' hypothesis is essentially benign, with its assumption that informal payment has no influence on the service delivered. Nonetheless, we have argued that this distinction matters only if the scale of informal payment is large enough to make a real impact. If the sums involved in the transactions are trivial than it is immaterial whether informal payments are 'donations' motivated by genuine gratitude or 'fee-for-service' motivated by the desire to secure adequate care.

The review of the theoretical literature has also shown that the answers provided to the question of 'why?' are unsatisfactory inasmuch as they concentrate solely on informal payments without taking into account the broader context within which they exist and the scope for alternative courses of action. Drawing on the 'fee-for-service' explanation, which considers informal payments as a reaction to unsatisfactory system performance, and the theory of 'exit, voice and loyalty', which considers the possible reactions to declining organisational performance, we argued for an extension of the 'fee-for-service' explanation with Hirschman's 'exit' and 'voice' to encompass a new

option whose most characteristic example is informal payments. We suggested a new term, internal/informal exit, abbreviated to 'inexit', to describe this option, since there are reactions to declining system performance that do not fit the categories of 'exit' and 'voice', and which resemble informal payments yet are not the same, such as informal private practice in public institutions. On the basis of the 'inexit' theory of informal payments, we offered explanations not just for the emergence of the phenomenon in Hungary, but also in other health care systems where the reactions to unsatisfactory system performance differed, considering the implications of the theory for policy. Nevertheless, the usefulness of these predictions is fundamentally determined by whether the 'fee-for-service' or the 'donation' explanation of informal payments applies, and the key distinction between the two is what motivates giving: gratitude or some form of external or internal pressure. During this discussion we contrasted the two explanations, but that does not mean that the two motives cannot coexist in the same system. The question is rather which is the dominant one, and in this respect only evidence of 'pure' gratitude can be invoked to support the donation hypothesis. Furthermore, by contrasting these two hypotheses, we have simplified reality in that we have emphasised the potential negative efficiency and distributional impact of a 'fee-for-service' like informal payment, while the potential of efficiency gains and a modest negative effect on equity cannot be excluded. This is indeed an important issue, but makes no difference if the benign, culturally motivated gift giving proves to be dominant.

Thus, the policy importance of informal payments depends on (1) whether their scale is substantial and (2) whether they are motivated by the desire to obtain adequate care. In the frame of this research we aimed to address both issues, but in the case of motivation, we looked at a wider range of evidence, including the impact on equity of informal payments, as well as directly exploring motivation itself.

9.3. Empirical findings

The empirical part of the study was justified by the fact that there are still powerful interest groups advocating the benign gratitude payment concept. They have had a profound impact on official policies ever since informal payments reached the policy agenda, as revealed by the conflicting evidence in the review of the existing empirical literature. Concerning the scale of informal payments we found a difference of an order of magnitude among survey findings and between survey findings and expert estimates. Evidence on the issue of motivation identified similar conflicts, including contradictions

between findings of different surveys and inconsistencies between stated motivations and circumstances of giving within particular surveys. When we reviewed empirical findings on motivation, we assumed that the responses ‘I was grateful’ and ‘it is customary to give’ obtained from questionnaire surveys were the operationalisation of the gratitude motive as understood by the ‘donation’ explanation (‘I am grateful, because the doctor restored my health’, and ‘I am grateful, because the doctor restored my health, and it is customary to express your gratitude by paying the doctor’). While we raised the issue that the ‘option’ of custom can be interpreted differently, for the purpose of this research we categorised it, together with ‘gratitude’ as a ‘non-coercive’ reason for giving, as opposed to all other motives, which involve some sort of pressure to pay.

9.3.1. THE FIRST MYTH: ‘INFORMAL PAYMENT IS A SUBSTANTIAL PART OF HEALTH CARE FINANCING’

On the basis of the collation and critical methodological review of official statistics and other survey findings, we estimated the overall magnitude of informal payments to be about 1.5-4.5% of total expenditures on health in 2001, which suggests that altogether it is not a substantial source of health care financing. Although there are still differences between estimates from various sources, by subjecting the findings to a detailed methodological critique it was possible to bring survey estimates closer to each other.

Table 9.1.

Research questions, hypotheses and findings of the study: Overall magnitude and distribution

Main objectives, research areas and questions	Hypotheses ('Donation')	Findings
To establish the magnitude and distribution of informal payments		
Q1. What is the overall amount of informal payment in a year?	indifferent	<ul style="list-style-type: none">• HUF 16.2-49.9 billion in 2001• 1.5-4.5% of total health expenditures in 2001
Q2. How is it distributed among health workers, especially physicians?		<ul style="list-style-type: none">• In average 75-230% of net salary of family doctors• In average 60-185% of net salary of specialists

Nonetheless, our analysis has shown that this relatively small overall amount can make a difference if it is distributed unevenly among health workers. On the basis of survey findings on the distribution of informal payments, we estimated that an average a family doctor earns at least 75% of their net official salary from informal payments, while for a specialist (in a ‘paying’ specialty) this is at least 60%, although in both cases the additional income may be up to double their salary (Table 9.1).

Our conclusion thus is that the policy importance of informal payments is not established primarily by the overall amount involved, but rather because they are unequally distributed among health workers. Thus, the general opinion that the overall amount of informal payments ‘must’ be substantial is a myth rather than a fact.

9.3.2. THE SECOND MYTH: ‘INFORMAL PAYMENTS ARE THE MANIFESTATION OF GENUINE GRATITUDE’

Given that the sums involved in the transaction have proved to be substantial at least in relation to the income of individual doctors, it does matter why people give. Thus, in chapters 7 and 8 we examined the motivation of giving with a focus on the validity of the gratitude payment concept. Table 9.2 summarises our findings in the two main research areas, the impact on equity of informal payments and the coercion to give. The assessment of the impact on equity of informal payments directly informs us about the policy importance of the phenomenon, but for ease of presentation we also organised these findings around the question of motivation.

Table 9.2. Research questions, hypotheses and findings of the study: Equity, private sector, motivation

Main objectives, research areas and questions	Hypotheses ('Donation')	Findings	Assessment*
To establish the impact on equity of informal payments			
Q3. Does it influence access to care?	No	<ul style="list-style-type: none">• Not first contact• Differential access in terms of service quality	+/-
Q4. Does it influence the distribution of cost burden of care?	Yes, but payment is the function of ability to pay	<ul style="list-style-type: none">• Yes, payment is probably not function of ability to pay, among those, who pay	-
To establish the main motivation of participants			
Q5. What is the principal motivation of the actors?	Gratitude	<ul style="list-style-type: none">• Gratitude and custom is dominant• Internal inconsistency• Custom is interpreted differently	+/-
Q6. Does the stated motivation fit in the circumstances of payment?	Yes	<ul style="list-style-type: none">• No	-

Notes: *+'=evidence supports the 'donation' hypothesis; '-'=evidence is against the 'donation' hypothesis; '+/-'=evidence is mixed;

As can be seen, the overall picture is not unequivocal in that not all evidence contradicts the ‘donation’ hypothesis. In particular, we see that informal payments are not a major barrier to access to services and that according to the two surveys the majority of such payments are motivated by ‘non-coercive’ reasons (gratitude, custom

or the combination of the two). On the other hand none of these findings refute the 'fee-for-service' hypothesis in themselves (for instance if physicians price discriminate according to patients' ability to pay), and there is further evidence in these areas to contradict the 'donation' hypothesis, most importantly the discrepancy between the motivation stated by respondents in the survey and the situation in which informal payments took place when explored through in-depth follow-up interviews.

First, the finding that informal payment is not necessary to obtain contact with the health care provider does not mean that there is no difference between 'paying' and 'non-paying' patients in terms of the quality of the service provided. In the secondary analysis of the TÁRKI-1996 survey we found significant associations between informal payments and the attention family doctors pay to hospitalised patients as well as the likelihood of receiving requested or unsolicited home visits, although whether these are causal associations requires further investigation. Further, the in-depth interviews have identified many ways that 'non-paying' patients may receive inferior care, for instance by physicians delaying interventions or paying no attention to them. While we have not analysed in detail the mechanisms involved, there is evidence from the interviews of how sophisticated techniques have been developed by doctors to differentiate between 'paying' and 'non-paying' patients over a prolonged period of time, using for instance one's signature on the discharge note.

Second, although the majority of respondents did opt for 'non-coercive' reasons of giving in the TÁRKI-1996 and the Kecskemét 2001 studies, more detailed analysis revealed internal inconsistencies among responses to various questions in both surveys. For instance, in the TÁRKI survey, respondents said to be motivated by gratitude felt pressure from doctors to pay, while in the Kecskemét survey, respondents used savings and gifts from others to cover informal payments. Further, the analysis of the reasons for non-payment in the Kecskemét 2001 study revealed that custom is often interpreted differently than might be implied by the 'donation' explanation of informal payments. Either it is directly related to the service ('it is not customary to pay for this particular service'), or to the 'non-enforcing, non-expecting' style of the individual doctor ('it is not customary to pay to this particular doctor').

Third, the most important evidence against the 'donation' explanation of informal payments is that when we explored the situation and the circumstances of giving in those cases in which respondents cited exclusively 'non-coercive' reasons of giving, we identified pressures on patients to give, either exerted directly by the doctor or indirectly by the unsatisfactory performance of the health care system (which together we called

the ‘coercion factor’). This suggests that surveys cannot accurately capture the motivation for informal payments, not primarily because respondents give biased answers, but because in practice the feeling of gratitude is inextricably intertwined with coercion. The interviews have provided an insight into how the provision of conscientious, high quality care can be interpreted as implying an expectation to give or as something ‘extra’ which must be paid for, in a system where patients generally anticipate substandard care. This new understanding of gratitude is different from the gratitude concept of the ‘donation’ hypothesis, insofar as the gratitude arises because of the avoidance of anticipated bad care rather than being ‘genuine’ gratitude.

In summary, the evidence presented in this thesis draws a mixed picture of informal payments in Hungary compared, for instance, with countries such as Georgia, where informal payments constitute the most important source of health care financing, and where informal payments are often overtly demanded by providers as a prerequisite to access care. This research has shown that such coercion by providers is not necessary for patients to feel obliged to give. First, there are more subtle forms of expectation, whose manifestations are gestures, hints and other aspects of the behaviour of the doctor, which sensitise patients to attribute certain meanings to common situations, reading them differently so that patients may perceive these pressures even if doctors have no such intentions. Second, failing system performance can also become a source of pressure to pay, even if providers do not want to elicit informal payments. In a system that provides uneven quality of care, the discrepancy between rhetoric and reality makes sub-standard care the normal, something that patients can anticipate receiving, so that good performance is regarded as something ‘extra’ that one must pay for out-of-pocket. It seems that these more subtle forms of coercion do not make informal payments a prerequisite to access care, but ‘non-paying’ patients can loose out in terms of the quality of care they receive and this becomes the background against which the health care system functions. In these circumstances the motivation for informal payments can rather be thought of as multi-layered, with gratitude playing a part, but with internal and external pressures on patients intertwined. Consequently, the evidence presented in this thesis suggests that the case for the donation hypothesis is weak.

Nevertheless, we have to take into account the limitations of the research, discussed in chapter 5 before we can make a more robust statement with clear implications for policy-making. The most important issue is the external validity of findings, which has been affected by the choice of study population, selection bias, non-responses, small

sample size and indirectly by respondent and recall bias. These are probably more marked concerning the equity impact of informal payments, which we rather consider a first exploration of the topic in Hungary, especially as it was not possible to analyse the impact of informal payments on the quality of services in sufficient detail. While on the basis of the findings of our research it is possible to draw a picture of informal payments for health care in Hungary and consider its implications for policy making, further research is needed to verify the findings of the qualitative interviews, possibly in a nationally representative survey and in qualitative interviews, including other interesting target groups, for instance with mixed ‘coercive’ and ‘non-coercive’ motives for payment.

9.4. Implications for policy-making

The most important implication of this study is that there is empirically grounded justification to consider informal payment as a problem and to do something about it. Yet one can argue that even a strong case for the economic explanation of informal payments is not enough to consider informal payments a problem, as it is still possible that their beneficial impact on system performance outweighs the negative consequences. Indeed, in chapter 3, we have discussed the possibility that informal payments improve the efficiency of the health care system if they alleviate shortages by influencing resource allocation at the macro level, while it may not have a strong impact on equity, if physicians price discriminate between patients according to their ability to pay. This is a key question, whose answer is complex. First, the claim that informal payment improves health system performance has to be backed up by evidence (an important area for future research). Second, it has to be demonstrated that there are no alternative options that have even more beneficial effects. Third, even if informal payments prove to be a powerful alternative to formal cost-sharing arrangements, policy makers have generally no discretion over the ‘rules of the game’. For instance, policy makers can not guarantee that all providers price discriminate, and that they will continue to price discriminate, even if there is evidence that providers, by and large, currently do so. Consequently, a weak case for the donation hypothesis does provide a justification to act, while the balance of the positive and negative effects of informal payments should be considered in deciding on the appropriate pace of changes and measures to be implemented.

While in the theoretical part of the thesis we have discussed the policy options that have been suggested so far, further research is needed to decide on what the best way is

to tackle this problem. In any case, a successful intervention has to consider the political complexities of the current system and the resistance that attempts to eliminate informal payments will inevitably evoke. There are beneficiaries of the status quo, some of whom would be worse off under any possible alternative to the current system. It may not be a coincidence that the myth of gratitude is so strongly favoured by, for instance, a certain part of the medical profession, and the gratitude motive provided justification for policy-makers to levy income tax on informal payments and to avoid raising the salaries of physicians to a reasonable level. Further, the success of interventions designed to eliminate informal payments depends on the knowledge we have about how the current system works. In this respect it is not enough to understand informal payments, but it is equally important to gain deeper insight, for instance, into the mechanism of 'exit' and 'voice'. In chapter 3, we used the theory of 'inexit' to provide recommendations for action. We argued that creating the conditions for a flourishing private sector as an alternative to public services is unlikely to benefit the public system, that entitlements should be reassessed for which the current unwritten entitlements (e.g. choice of doctor) established by informal payments provide a starting point and the opportunity to incorporate additional private financing, but any hypotheses derived from the explanatory framework require further empirical verification. While the objective of the empirical part of this thesis was to answer the underlying question of whether anything should be done about informal payment, the qualitative part of the study provided an indication what to do about it. However, given the limitations of qualitative interviewing discussed in chapter 5, the following points should rather be considered as a starting point for further research.

There are two implications of the economic explanation. First, taxing informal payments is not an appropriate policy, even if it had been possible to design and implement a better taxation policy on the basis of evidence related to the scale of informal payments. Second, successful policies have to tackle shortage in the health sector, since unrealistic regulations are seen as illegitimate by both patients and doctors. Enforcing non-payment and non-acceptance can only be a complementary measure, as it makes sense only if the available resources are in line with what the system promises to deliver. This can be achieved either by curtailing the generous benefit package and/or incorporating additional funds by formalizing informal payments as co-payments. It is not unreasonable to think that the private insurance market will expand if there are sizable co-payments and exclusions from the benefit package, as has been the case in Slovenia. Freeing up resources within the existing level of expenditures can

also be envisaged if the technical efficiency of the system can be improved. As we have argued in chapter 3, moving from the dilution of services to explicit waiting lists is another possibility, but it is unlikely to be the best choice if we aim to keep the majority of quality-conscious consumers within the public system.

Mapping informal payments can help to design a co-payment system that is most likely to be accepted by the population (e.g. free choice of doctor, home visits). While formalizing payments can be seen as a way to restrict unnecessary use and thus free up resources within existing level of expenditures, it cannot be assumed that the existence of formal out-of-pocket payments will prevent patients from paying additional sums. Indeed, payment is likely to continue unless patients have no concern that the system will fail to deliver effective care without such additional incentives. The interviews have confirmed the importance of distrust in the genesis of informal payments. This distrust is most probably sustained by direct and indirect bad experiences with the performance of the health care system, thus, we argue, that attempts to eliminate informal payments must involve concerted action to rebuild the lost social capital (trust) in health care. The key issue is to ensure a uniformly good quality of care, but in this respect it is important also to use funds to raise the salaries of health workers. This should be linked to innovative methods of accountability that promote transparency, while local initiatives, which build on partnership and participation, could re-establish the trust-based relationship between the lay public and physicians and thus provide a different set of expectations for their future encounters.

Nevertheless, these points, especially the central role of distrust in informal payments, need further empirical verification possibly in a nationally representative survey. We must know more about informal payments, as in many respects this research has prepared the ground for future research.

9.5. Implications for research: an extended research agenda

One starting point for future research is the agenda we outlined in chapter 4. In the frame of this research we have not addressed all the main topics and questions suggested there. For instance, one research topic that is almost unexplored so far is the comparative analysis of health care systems where informal payments do or do not exist. In terms of direct policy-relevance, however, I would suggest concentrating on exploration of private sector informal payments and the ‘exit’ and ‘voice’ mechanisms in health care. These options certainly could play a role in eliminating informal payments, but, as we have discussed in chapter 3, there are potential risks involved in

finding the optimal balance, as we would not wish to end up in a situation in which patients suffer more.

As we have discussed before, the actual impact of informal payments on efficiency and equity is also important for policy making, as this has implications for the appropriate measures and the time frame for eliminating them. Focussing on the motivation issue, we have only indirectly established their impact on efficiency, while the equity of informal payments could not be explored in detail because of the limitations of the study design. In this respect one of the crucial issues to be researched is provider behaviour, which has been explored only in qualitative interviews in this thesis. For instance, price discrimination is a possibility, which may enrich the positive aspects of the fee-for-service explanation. The interviews have indicated that the question of the extent to which physicians can influence the actual amount of informal payments, or can refuse payments that have been offered, is by no means straightforward and merits further attention.

An extended analysis of our in-depth interviews is one practical starting point for future research, as they yielded valuable data on private sector informal payments and about 'voice' and 'exit'. The study of current reform initiatives and local pilot projects, such as the managed care pilot project, is another possibility. Even now the knowledge available is limited, with many unexplored areas, yet the topic is attracting increasing interest at both national and international level.

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APPENDICES

APPENDIX A.

A. THE HEALTH CARE SYSTEM AND HEALTH CARE REFORMS IN HUNGARY

The aim of Appendix A is to place informal payment in the context of the Hungarian health care system and in particular, the changes that have taken place in the past 15 years.

A.1. Health and the health care system in transition: where is Hungary now?

The first section of Appendix A briefly summarises the economic, social and political context, which has already been introduced in chapter 1. Next the health status of the Hungarian population is described, with an assessment of trends in the post-war period. The final section outlines the current organisational structure of the system, introducing the systems of financing, service delivery and governance in more details on the basis of the documentary analysis of statutes and analysis of official statistics.⁵⁶

A.1.1. Economic, social and political context

In chapter 1, the economic, social and political context of the Hungarian health care system was briefly discussed. Table A1.1 provides a summary of the most important elements to serve as a reference point for the following discussion of the organizational structure, and recent reforms of the Hungarian health care system.

As mentioned previously, the Republic of Hungary has been a liberal democracy, operating a market economy since the collapse of the communist dictatorship in 1990. General and local elections take place every four years, when political parties compete for the leadership of the three levels of public administration: national (central) government, county governments and settlement governments (municipalities). Election rules has selected 4-6 parties, which are able to collect sufficient number of votes to send members of parliament to the National Assembly. Since 1990 voters always punished the governing parties, enabling the opposition to form coalition governments [167].

The transition from a centrally planned command economy to a market economy is generally viewed as having been successful. The economic recession in the first half of the 1990s led to imposition of a strict fiscal policy and the country has experienced fast and steady economic growth since 1997 (See Table 1.2. and Figure 1.4). Nevertheless, the transition period took its toll. In 1999 real wages were still only 85% of their 1989 level, whilst the income gap between the poorest and the wealthiest 10% of the population rose from an 3.5 fold difference in 1970 to a 5.5 fold difference in 1999 [27; 28].

⁵⁶ For a more extended discussion of the Hungarian health care system see the Health Care Systems in Transition series of the European Observatory on Health Care Systems (Gaál et al. [11] and Gaál: Health Care System in Transition: Hungary. Copenhagen: European Observatory on Health Care Systems [29]).

A low birth rate means that the population is simultaneously shrinking and aging. The share of the elderly, aged 65 or over, in the population increased by 52% between 1960 and 1980, and by another 11% between 1990 and 2000, while the total fertility rate has been below 2 since 1980, and has decreased further since 1991 (see Table 1.1. and Figure 1.2).

The political, economic and demographic transition together with the legacy of the state-socialist health care system have all been shaping the health of the Hungarian population since the collapse of the communist regime.

Table A1.1. Country background information, 2000

Political system	Liberal democracy
Parliament	Unicameral (386 seats)
Election cycle	4 years
Electoral system	majority and proportional
Ruling party	Coalition led by the Hungarian Socialist Party (2002-)
Public administration	3 levels: central government county local governments municipalities (settlement local governments)
Economic system	Market economy
GDP per capita	4,621 USD
GDP growth rate	5.2%
Annual inflation (Consumer Price Index)	14.3%
Unemployment	8.7%
Population	10.1 millions, ageing
Population change	-3.8 per 1,000 inhabitants
Ageing index	82.5%
Language	Hungarian
Largest ethnic minority	Gypsy (estimated 5%)
Religion	Catholic (64%)
Life expectancy at birth	67.1 years (male); 75.6 years (female)
Mortality	13.5 per 1,000 inhabitants
Infant mortality	9.2 per 1,000 live births
Maternal mortality	10.2 per 100,000 live births
Communicable diseases mortality	0.5% of all deaths
Cardiovascular mortality	51% of all deaths

Source: [12]

A.1.2. HEALTH STATUS OF THE POPULATION

In the period since the end of the Second World War the health status of the Hungarian population has passed through four main phases (see Figure 2.1). The first period, until the end of the 1960s, saw a major improvement that brought life expectancy to a level comparable with the more developed Western European countries. The early efforts in public health, including widespread immunization programmes, undertaken by the communist regime, coupled with improvements in the socio-economic situation successfully brought communicable diseases under control, with a substantial increase in life expectancy for both sexes [158]. These changes took the health of the Hungarian people through the first phase of the health transition, with non-communicable diseases achieving greater prominence during the 1970s. Yet while life expectancy continuously improved in Western European countries during the 1980s, it stagnated in Hungary, and

rising adult mortality would have actually caused it to decline had it not been counterbalanced by continuing improvements in infant mortality (Table A1.2). This second period, from the beginning of the 1970s till the end of the 1980s, was characterized by an increasing health gap between Hungary and Western Europe. A similar pattern was seen in other Central and Eastern European (later referred to as CEE) countries, such as Poland and the Czech Republic, although Hungary did rather worse than its neighbours [283].

The fall of the communist regime brought about a third period, which was characterised by a marked decline in health status, further widening the gap between Hungary and the countries of the European Union (EU). Life expectancy at birth decreased by more than a year between 1988 and 1993, whilst it steadily increased in the EU as a whole. In addition, the gap widened in relation to the Czech Republic and Poland, where the effect of the transition period was less marked, and recovery had begun much faster. Nevertheless, a late recovery started in 1994, and since then a steady improvement in life expectancy has occurred, which at least ensured that the gap between Hungary and its neighbours has not increased.

However life expectancy at birth in Hungary remains among the lowest in Europe. In 1998 it was 70.7 years, almost 8 years lower than the EU average, 3 years lower than the European average, 1.6 years lower than the CEE average and 4 and 2.4 years lower than in the Czech Republic and Poland, respectively [107]. The high mortality among middle-aged men is the single most important factor explaining this gap. In 1993, 16 out of 1000 men between the age of 40-59 years died, a rate twice as high as in 1970. Male life expectancy at birth was almost 2 years longer in 1970 than in 1993 [20; 31].

Table A1.2. Trends in mortality-based indicators, 1949-2000 (selected years)

	1949	1970	1980	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Male life expectancy at birth (years)	59.3	66.3	65.5	65.4	65.1	65.0	64.6	64.5	64.8	65.3	66.1	66.4	66.1	66.3	67.1
Female life expectancy at birth (years)	63.4	72.1	72.7	73.8	73.7	73.8	73.7	73.8	74.2	74.5	74.7	75.1	75.2	75.1	75.6
Infant mortality per 1,000 live births	91.0	35.9	23.2	15.7	14.8	15.6	14.1	12.5	11.5	10.7	10.9	9.9	9.7	8.4	9.2
Maternal mortality per 1,000 live births	1.57	0.42	0.20	0.15	0.21	0.13	0.10	0.19	0.10	0.15	0.11	0.21	0.06	0.04	0.10
Crude death rate per 1,000 population	11.4	11.6	13.6	13.7	14.1	14.0	14.4	14.6	14.3	14.2	14.0	13.7	13.9	14.2	13.5
Mortality of 40-59 year-old males per 1,000 population	10.0	8.4	12.5	...	14.3	...	15.6	16.0	15.9	15.4	14.2	15.2	14.2	14.3	13.1
SDR, all ages, per 100,000*	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
all causes	...	1252	1302	1230	1262	1252	1284	1296	1257	1233	1205	1174	1183	1193	1124
external causes	...	97	114	115	121	118	119	112	108	102	97	92	93	92	85
suicide and self-inflicted injuries	...	35	44	40	38	37	37	34	34	31	31	29	30	31	30
cardiovascular diseases	...	690	683	625	645	638	640	647	614	604	602	579	586	588	548
ischaemic heart disease	...	248	229	235	240	244	250	261	250	254	257	252	256	254	238
cerebrovascular diseases	...	185	218	172	177	174	172	170	161	162	163	152	154	153	149
malignant neoplasms	...	216	240	260	267	271	279	278	280	281	284	284	284	285	279
cancer of lung, bronchi, trachea	...	32	45	57	61	62	64	66	66	66	68	68	69	68	67
digestive system diseases	...	45	63	80	82	83	99	109	111	108	91	90	95	93	90
chronic liver diseases and cirrhosis	...	13	27	50	51	55	68	79	81	80	63	63	67	67	63

Note: *SDR = age-standardized death rate

Source: [21; 20; 19; 18; 30; 31; 16; 32; 15; 33; 14; 34; 12]; *[107]

The immediate causes of death that account for the gap with the West are common to other countries in transition: cardiovascular diseases and external causes, among which suicide is a particular problem (see Table A1.2). In addition, however, Hungary is characterised by especially high levels of lung cancer and, like its neighbours, Slovenia and Romania, cirrhosis [107].

How can we explain these grim figures? Clearly, the answer will lie in an understanding of the broad determinants of health. There has long been concern about the Hungarian lifestyle, especially smoking, alcohol consumption, and the traditional, but unhealthy Hungarian diet [107]. For instance, the death rate from causes directly attributable to alcohol is much higher than the CEE average, itself much higher than that in the EU.

But why do Hungarians display such self-destructive tendencies? Kopp [108] offered an interesting explanation of this phenomenon. Analyzing the social and psychological determinants of health, she found that social support and social cohesion are important contributors to good health, but they had been eroded in many ways throughout the past 30 years. Inequalities in income have risen substantially, partly as a result of the liberalization policy that characterized the “goulash” communism, where reform began earlier in Hungary than in other CEE countries. At the same time, traditional channels of social support have gradually been disappearing. She found that low income does not in itself lead to ill-health, but is mediated by depression, so that people who feel their situation poor and hopeless are more likely to become ill and turn to alcoholism and suicide.

Nevertheless, health services do play some part in population health. Although during the communist regime everybody, in principle, had access to the service he or she needed, the appropriateness and the overall quality of service were questionable. The state-socialist system was unable to respond adequately to the health transition experienced by the population, and the allocation of resources was subject to political influence. Hence inequalities in service provision arose in terms of both geographical locations and specialties [109; 39; 40].

Concerns about health in Hungary are not just that the country lags behind the EU and other CEE countries at similar level of economic development, but that there are persisting geographical and social inequalities in health. For instance, the gap in life expectancy at birth between counties with the highest and lowest levels was 6.7 years for men and 4.3 years for women in 2000 [110]. The difference is partly attributable to the presence of disadvantaged population groups, especially the Roma minority, whose concentration is greatest in the three northern counties of Heves, Nógrád and Borsod-Abaúj-Zemplén [284]. Unemployment is much higher in the Roma population than among ethnic Hungarians and many live in slum conditions without running water and sewerage. Their health is substantially worse than that of their ethnic Hungarian neighbours [111].

In summary, the health status of the Hungarian population is among the worst in Europe. Hungary has to face both the challenges of an aging population and a high rate of premature death, in particular due to cardiovascular diseases, malignant neoplasms, chronic liver diseases and suicide. Inequalities in health, and in particular the problems faced by the Roma minority, raise further concerns. Hence, the challenges facing the Hungarian health care system are especially complex, a situation that is partly attributable to the failures of the system itself.

A.1.3. OVERVIEW OF THE HUNGARIAN HEALTH CARE SYSTEM

The evolution of the Hungarian health care system in the 20th century can roughly be divided into three main periods. Before the Second World War both the financing and the delivery of health services were characterised by a public private mix, with health insurance gaining ground rapidly and increasing state involvement in the Bismarckian model [66; 153]. This development was disrupted at the end of the Second World War, when the integrated state-socialist model of health care systems was established over a short transition period of five years. The 1949 Hungarian Constitution declared health to be a fundamental right for which the state was held responsible [285]. Throughout the communist period this meant that the state assumed exclusive responsibility for both the financing and delivery of health services. The Ministry of Health funded and delivered the whole spectrum of health services including hospitals, polyclinics and the district doctor services that were established in 1952 [156]. Although private practice by physicians was not totally banned, it was only permitted on a part time basis [157,39(2)b].

The need for radical health care reforms became increasingly apparent in the 1980s, coinciding with signs of incipient collapse of the centralised economic and political system. The widening gap in health status between Hungary and Western European countries called for profound change and the softening political climate opened the way for reform, which began in the last years of the communist regime. Major health care reform has been on the policy agenda ever since.

The current structure of the Hungarian health care system represents a considerable departure from the former, highly centralized, state-socialist model. Since 1989 the system has become more pluralist with responsibilities divided between various players, while the previous hierarchical relationships have partly been replaced by contractual relationships and quasi-public arrangements (Figure 2.2).

In contrast to the Semashko system, the new model is based on contracts, in which purchasing and service delivery are separated, although the current Hungarian health care system is still predominantly publicly financed and provided. Health services are financed chiefly from compulsory social insurance for recurrent costs, and from taxation for capital costs. Within the framework of the social insurance system the statutory health insurance scheme is a distinct entity. Contributions are held in an earmarked budget, the so-called Health Insurance Fund (later referred to as HIF), which is administered by the National Health Insurance Fund Administration (later referred to as NHIFA) [117; 118]. The NHIFA is the single most important monopsonistic purchaser in the system. However the rules within which it acts, such as contribution levels, its operating budget, and methods of provider payment, are made by the National Assembly, the national government and within that the Ministry of Health, Social and Family Affairs (later referred to as MOH). [119,19; 2,34,35; 120-122]

Local governments are the main service providers in the system, owning most health care facilities, including primary care surgeries, polyclinics and hospitals [43,107(1)c; 129]. While local governments are responsible for making health services available for the local population, they are allowed to contract out service delivery to private providers. Nevertheless, the private sector is small except for primary care, whereas most family doctors work as independent entrepreneurs, although their surgeries and equipment are owned and made available for them by local governments (a scheme

known as ‘functional privatisation’). Service providers, whether public or private, have to contract with the NHIFA to become eligible for HIF funding [2,30-33,36-38; 131,13-25].

The national government is the dominant regulator of health services, exercises statutory supervision over the HIF and controls the NHIFA [133-135; 121], covers the deficit of the HIF [119,3(2)], pays premiums in respect of non-contributing groups [119,39(1),16(1)b-o; 123], provides capital funds [125], finances and delivers public health services and provides most tertiary care services, mainly through the MOH [1]. The government also finances health education, research and development, and co-payments that would otherwise be paid by the poor [136-138].

In the next sections, health care financing, delivery and governance are reviewed in more detail.

A.1.3.1. Health care finance and expenditures

This section aims to give additional insight into the flow of funds through the system: revenue collection, budget setting, financial resource allocation and payment. Trends in public and private sources and health care expenditures are also reviewed with a brief discussion of available data and their limitations. One important source of concern about the validity of published figures relates to estimates of the scale of informal payment, which is a topic of this thesis and addressed in greater depth in chapter 7. In this section health care expenditures and sources of finance are calculated using the best available estimates on informal payment.

As it has already been mentioned, public sources of health care finance consist of revenues from general and local taxation, but more importantly from contributions to the statutory health insurance scheme. The revenue of the HIF comes from health insurance contributions [119,24] and from the so-called ‘hypothecated health care tax’ [123]. The health insurance contribution is paid partly by the employer and partly by the employee in the form of a proportional payroll tax, whilst the hypothecated health care tax has two components: a lump sum tax and a proportional tax, levied on those types of income which are not subject to social insurance contributions, for instance certain dividends or fringe benefits. The statutory health insurance scheme provides almost universal and comprehensive coverage, with few exclusions and no or little co-payment, except for pharmaceuticals, medical aids and prostheses [2,18(4-6),21,23]. Private sources of health care financing, though, are almost exclusively out-of-pocket, since the private health insurance market is insignificant [124].

Main system of finance and coverage

As a general rule the HIF covers only the recurrent costs of services. The owners of health care facilities, mainly local governments, are responsible for maintenance according to *Act CLIV of 1997 on Health* (the principle of ‘maintenance obligation’) [1,155(2)]. They are obliged to cover the capital costs of services (depreciation and investment), which usually come from general and local taxation. In addition to locally collected revenues, central government offers substantial help via conditional and matching grants [125].

Act LXXX of 1997 on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services determines the rules of participation in the

statutory health insurance scheme, and entitlement to in-kind and cash benefits. Membership in the health insurance scheme is compulsory for everybody; opting out is not permitted. The population is divided into three groups: (1) employees and entrepreneurs, (2) those who are covered, but do not have to contribute, including the dependants of group one and certain special groups – for instance pensioners, those who are on maternity leave, conscripts, the ‘socially indigent’ – and their dependants, (3) all other residents holding a personal identification card [119,2(1),5,11,39]. All three groups are entitled to health services, but only groups one and three have to pay health insurance contribution. As a result population coverage is virtually universal with less than 1% not covered. For instance, foreigners, who work in Hungary for a prolonged period are not obliged to participate, but may do so, if they wish. The homeless and unregistered workers may not be covered, if they do not register at the local government as socially indigent [138,54]. Health services are provided on the basis of a unique personal identification number, but there is currently no system in operation by providers to check whether contributions have actually been paid [286,21-27].

The health insurance contribution is split between employer and employee [119,18]. The proportional contribution is universal and determined annually by the National Assembly. In 2001, social insurance contribution was 42% of the gross salary from which 14% went to health. Employers paid 11%, whilst employees paid 3% of their gross salary [119,19]. There was initially an upper ceiling for the employee contribution, but it was abolished by the government as of 1 January 2001 [119,24(2); 181,153(1)]. Special rules apply to the self-employed, who must pay contributions according to the nationally determined minimum wage, and to small farmers, who can choose to pay only 11% of the actual minimum wage, but they are not entitled to cash benefits [119,29,39(2)]. By paying the full 14% contribution, they can get full coverage, including cash benefits [119,34(3)].

Provisions for non-contributing groups are shared between the HIF and the government. Those who are on sickness and disability benefits should be covered from the Fund, while the government transfers the revenue from the ‘hypothecated health care tax’ to the Fund to compensate for the rest of group two, as mentioned before [119,39(1)]. This new hypothecated tax was introduced in 1996 as a lump sum tax, which has to be paid in addition to the social insurance contribution as of 1 January 1997 [175; 287]. In 2002, it was HUF 4,500⁵⁷ per month [123,9]. Later it was complemented with a proportional 11% tax, which has been levied since 1 January 1999 on those types of income previously exempt from social insurance contributions [123]. As a result, the employer and employee health insurance contribution and the ‘hypothecated health care tax’ now constitute the two major revenue sources of the HIF.

The chronic problem facing the HIF is that it has been in deficit since its inception [288-295]. Successive governments over the past 10 years have targeted the funding of the statutory health insurance system, and only minor modifications have been implemented in the almost comprehensive and universal benefit package.

The provision of universal and comprehensive coverage was the founding principle of the previous, state-socialist health care system. Health services were free-of-charge except for very small co-payments for medicines, medical aids and prostheses [252,25(1)]. In the early years of the transition from the tax funded integrated system to

the social insurance funded model more emphasis was put on structural reform than setting priorities in terms of health care benefits. In parallel with the establishment of statutory health insurance, a negative list of free services was defined in amendments to *Act II of 1975 on Social Insurance*, which has not been modified substantially since then [296,4-5; 297].

Act LXXXIII of 1997 and related decrees define health services, which are (a) free-of-charge, (b) covered partially (co-payment has to be paid), or (c) excluded from statutory health insurance coverage. The starting point of the Act is that all health services are fully covered and exclusions are stipulated. Co-payment is required for medicines, medical aids and prosthesis, balneotherapy [2,21], dental prosthesis, treatment in sanatoria, long-term chronic care (HUF 400 per day⁵⁸) and some higher quality 'hotel' services for inpatient care, such as en-suite single rooms and other modern conveniences. Co-payment is applied if certain rules are not observed: (1) if specialist services are obtained without a referral from authorized medical doctors, except in the case of emergency, (2) if patients choose to go to a provider other than the one they were referred to, (3) if patients want to have more services than the doctor prescribed [2,23; 3]. Between 1996 and 2001 co-payment also had to be paid for tooth-preserving dental treatments, but this has recently been abolished [168; 169; 2,23(b); 298; 299]. Special rules apply to a few services, such as infertility treatments, where the number of cycles is limited [300]. The costs of medical examinations for certificates required for driving and firearms are not covered, and the Act explicitly excludes treatments for aesthetic or recreational purposes and those not proven to be effective in improving health [2,18(4-6)]. These include services not included in the International Classification of Medical Interventions as well as cosmetic surgery, massage, abortion or sterilization without medical indication, and prostate specific antigen test in general screening [4]. Some other health services, like high-cost, high-technology interventions and patient transport have also been excluded, but are covered from the central government budget [2,18(5); 1,142(2)].

Complementary sources of finance

Private sources are almost exclusively out-of-pocket payments for informal payment and for services, which are either partially or fully excluded from cover by the statutory health insurance scheme, since private for-profit and non-profit health insurance has not yet become well established. As well as the cases of co-payments and exclusions listed previously, patients pay the full price for services that are obtained from a private provider who has no contract with the NHIFA [2,9].

The market for private for-profit and not-for-profit health insurance is small, and consequently an insignificant source of health care financing. Voluntary health insurance was non-existent under the previous regime. *Act XCVI of 1993 on Voluntary Mutual Insurance Funds* created the legal framework for non-profit insurance plans, according to the model of the 'mutualité' movement. Although the government subsidizes the purchase of health insurance from voluntary mutual funds by means of a 30% tax rebate, up to a certain limit [301,35(2)], so far few voluntary funds have been established. In 1998 there were approximately 30,000 members in less than 30 funds

⁵⁷ €18. 1 EUR is approximately 250 HUF.

⁵⁸ €1.6.

with a total revenue of HUF 600 million⁵⁹ [124]. In exchange for a 'membership fee', the existing plans are allowed to offer services not covered, or not fully covered by the HIF [164,51(1)]. Only a small portion of the 'membership fee' is a real health insurance premium, paid into a common fund, or risk pool. The larger share of contributions goes to individual accounts and can be used by the account holder only, so that they are, de facto, medical savings accounts [164,51(5)].

Private for-profit health insurance is even more limited. Some companies offer insurance at the upper end of the market, mainly cash benefit schemes for certain illnesses [302; 303]. There are new attempts to extend the private health insurance market by offering in-kind benefits in the form of higher quality hotel services, but there is no published evidence about the extent of demand for these plans.

Budget setting, financial resource allocation and provider payment

Figure A1.1 presents an overview of the flow of funds in the Hungarian health care system, from households, patients and firms to individual providers.

The health care budget is made up of three components: (a) the HIF, derived mainly from social insurance contributions and from the hypothecated health care tax, (b) the central government budget derived from general taxes, and (c) local government budgets that come from local taxes, from the central government on a capitation basis and via conditional and matching grants for investment. Most key budget setting decisions are made at national level by the government.

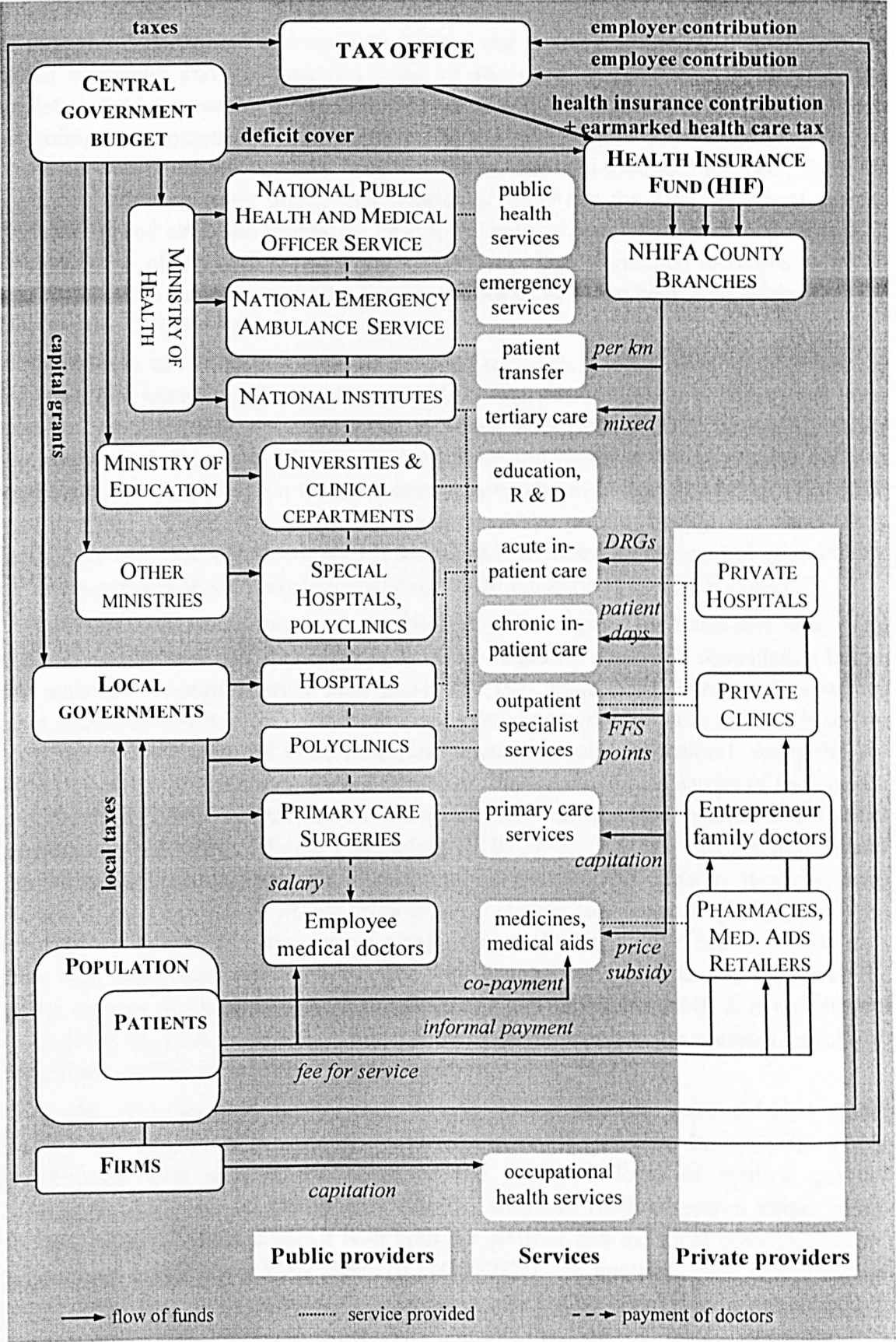
A key principle of resource allocation is the separation of capital and recurrent costs. The main source of recurrent financing is the HIF, while the owners of health care facilities, mainly local governments, are responsible for capital costs, according to the principle of maintenance obligation [2,35(2); 1,155(2)]. The HIF is divided into over twenty budget lines (sub-budgets) according to service types. For example family doctor services, dialysis and acute inpatient care, all have their own sub-budgets, which are unified at the national level, i.e. not devolved to the counties [e.g.126,Annex 1].

Another key resource allocation principle is the protection of the HIF from cost explosion. A national budget ceiling is set for most sub-budgets, and various payment methods are used to ensure that the budget is not exceeded: capitation, global budgets or a point system, when health care providers are reimbursed on the basis of services produced [2,34; 127,22-30; 120]. Nonetheless, the sub-budgets of pharmaceuticals and medical aids and prosthesis were exceptions and overspending in these sub-budgets was one of the main causes of the deficit of the HIF [see for instance 304,Annex 2]. Reallocation of funds between sub-budgets was not permitted until 1999, when the Minister of Health was granted the right to compensate overspending in these non-capped sub-budgets from other sub-budgets of the HIF [126,5(3); 305; 306; 307,Annex 5].

Health service providers are paid from the sub-budgets of the HIF by various methods: outpatient specialist services are paid on a fee for service basis, using a points system (points for procedures), acute inpatient care is reimbursed using diagnosis-related groups (DRGs), and chronic care by patient days [2,34; 127,22-30; 120; 122].

⁵⁹ €2.5 million.

Figure A1.1. Flow of funds in the Hungarian health care system



The points system works as follows: each procedure (in outpatient specialist care) or case (in acute inpatient care) is assigned a certain number of points on the basis of its

complexity and use of resources (the so-called 'German points' for procedures and DRG points for hospital cases). Providers calculate their monthly sum of points on the basis of procedures performed and cases discharged and report it to the NHIFA. Points are added nationally and the monetary value of one point is calculated by dividing the predetermined sub-budget by the total number of points [308,20(10)]. Payment is made according to the points collected multiplied by the calculated national monetary value of one point (the so-called 'national base fee'). The 'national base fee' has been fixed for a year in advance since the second quarter of 1999 for the DRG payment system [120,38(3)] and since the middle of 2000 for outpatient specialist services [309,16(4)]. Recalculation of the national base fee applies only if performance increases so much that it cannot be compensated from the reserve put away at the beginning of the year for this purpose [120,38(3-6)].

In addition to the main system of payment methods, special rules apply to certain services. For instance, a few high-cost medical interventions, such as kidney and bone marrow transplantation, are reimbursed on a case basis [309, 44; 122,Annex 8]. Other high-technology therapies, like heart, lung, liver and pancreas transplantation are also paid for on a case basis, but from the central government budget [2,18(5)g; 1,142(2)d; 4,Annex(1)]. There are certain services, such as public health and emergency ambulance services, which are both financed and delivered by the central government, i.e. financing and service provision have remained integrated [1,142(2)a-c,e-g].

Service providers contract with the NHIFA to be eligible for reimbursement. The contract defines provider capacities in terms of outpatient specialist consultation hours, and acute and chronic hospital beds [2,31; 131,19]. Until 2001, contracted capacities were legally determined for each county and speciality, according to a formula based on local health needs (on the basis of certain socio-economic indicators), while the so-called 'county consensus committees' agreed on the contracted capacities of each health care provider [139]. In 2001, the *1996 Capacity Act* was repealed, and the actual status quo became the basis of future contracting [310; 311]. The law has allowed greater flexibility for local governments to restructure capacities, but capacity increases have remained the prerogative of the Ministers of Health and Finance [310,3(2)]. The quantity and quality of outputs are not stipulated in the contract, except for a few high cost, high technology interventions, like various organ transplantations, for which the yearly number of procedures is set in advance [120,44(2)]. The NHIFA is not allowed to exercise selective contracting, but has the right to monitor the contract, mainly to control the validity of providers' performance reports [2,36-38].

In the state-socialist health care system all physicians were salaried public employees, and private practice was allowed only on a part-time basis [157]. Public employment with salaries has remained the dominant form of medical practice throughout the years of health care reform, with the only exception being family doctors, most of whom contract with both the NHIFA and the local governments and are paid on a capitation basis [46; 120,11(1),12(2)]. In contrast, most specialists are public employees, with nationally agreed pay scales [128]. The salary is determined by qualifications and years of experience. Until the end of 2002, when the new government instituted a 50% pay rise [312], the average salary in the health sector was lower than in most other sectors of the economy [30; 18; 17; 31; 16; 32; 15; 33; 14; 34]. In 2000, health care workers were the fifth lowest paid among the full-time employees of the 14 main sectors of the Hungarian economy [12,4.12,p.90]. The situation was

even worse when compared with the average salary of workers with higher education qualifications. The health sector ranked as the second worst paid among the other main sectors [12,4.16,p.96].

Trends in sources of financing and health care expenditure

In 2000, Hungary spent 6.3% of its GDP on health care, 82.6% of which came from public sources according to international and national statistics. International sources suggest a somewhat higher figure of 6.8% for health care expenditures, and lower share of public expenditure of 73.5% (Table A1.3. and A1.4). This variation is attributable to two factors: (1) the divergent estimates of informal payment, and (2) the difference in estimates of tax-financed services and capital expenditures. For instance Orosz et al. [112] estimated informal payment as 0.6% of GDP between 1989 and 1996, which alone made up 7-11% of total health expenditures. At the same time estimates from the regular household budget survey of the Hungarian Central Statistical Office (HCSO) were between 0.06% and 0.11% of GDP [260; 253; 76; 261; 254; 255]. Estimates of the sources of entirely tax-funded services and tax-funded capital expenditures are the other main reason for conflicting data on health expenditures. For instance, the estimates by Orosz et al. [112] range from 0.9% to 1.4% of the GDP, between 1991 and 1996, and for the same period OECD figures are between 1.1% and 1.8% [114]. The lowest difference in a particular year is 0.1% of GDP, while the highest is 0.4%. Apart from these uncertainties, statistics for HIF and private pharmaceutical expenditures are believed to be accurate. Tables A1.3 and A1.4 have been put together primarily on the basis of these data, complemented with the best available estimates from international sources, but the corresponding figures extracted from the WHO Health for All Database and OECD Health Data, along with the estimates of Orosz et al. are also shown [116; 107; 113-115; 112].

Table A1.3. Main sources of finance (%) in the Hungarian health care system, 1989-2000

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Public	91.1	91.7	92.5	91.1	90.5	90.9	88.8	88.4	87.8	87.7	85.7	82.6
statutory health insurance	0.0	78.5	75.7	73.8	71.8	71.2	70.3	73.6	75.1	75.1	72.9	69.9
taxes	91.1	13.2	16.7	17.3	18.7	19.7	18.6	14.8	12.6	12.6	12.7	12.7
Private	8.9	8.3	7.5	8.9	9.5	9.1	11.2	11.6	12.2	12.3	14.3	17.4
out-of-pocket	8.9	8.3	7.5	8.9	9.5	9.1	11.2	11.6	12.2	12.3	14.3	17.4
private insurance	-	...	...	...	...	...	...	...	...	...	...	...
Other (external sources)	...	...	...	...	...	...	...	...	...	...	...	...
Public*												
WHO [107]	100.0	100.0	80.8	79.1	79.4	80.0	76.2	76.5	75.3	76.5	75.0	73.5
OECD [115]	...	...	90.1	88.3	87.0	86.7	84.0	81.9	80.0	82.4	...	...
WB [112]	86.0	85.7	87.7	88.2	87.0	86.7	83.3	82.7	-	-	-	-
Private*												
WHO [107]	0.0	0.0	19.2	20.9	20.6	20.0	23.8	23.5	24.7	23.5	25.0	26.5
OECD [115]	...	...	9.9	11.7	13.0	13.3	16.0	18.1	20.0	17.6	...	...
WB [112]	14.0	14.3	12.3	11.8	13.0	13.3	16.7	17.3	-	-	-	-

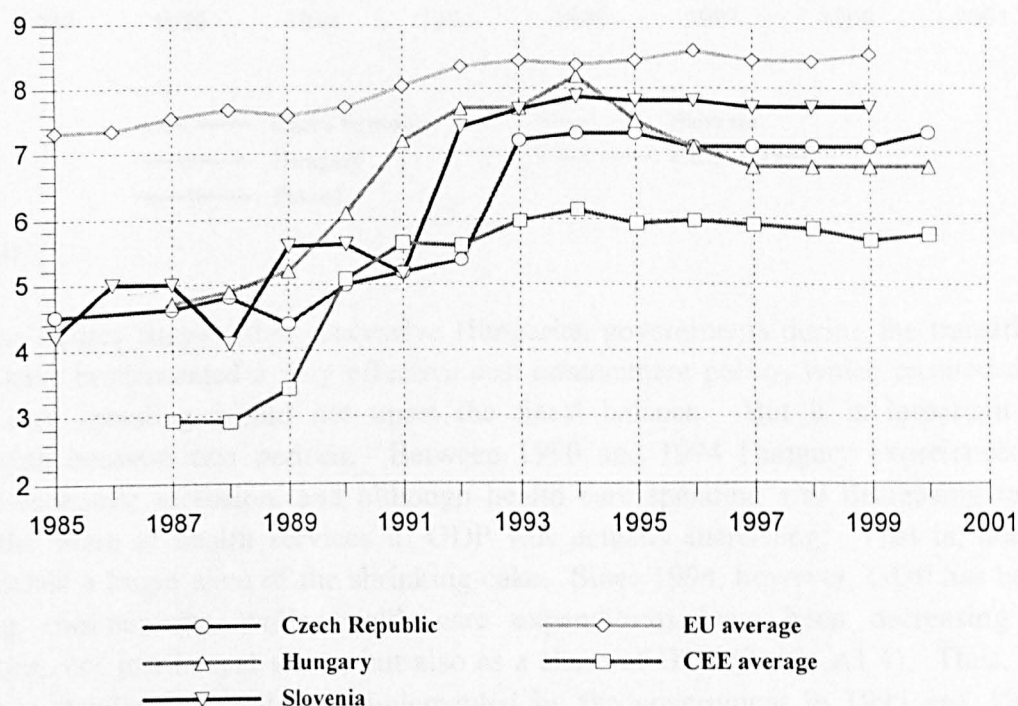
Note: Estimates for the public and private share of health care expenditures from the WHO Health for All Database for 1989 and 1990 are certainly not valid, since informal payment and co-payment for pharmaceuticals did exist in the state-socialist health care system.

Source: Calculated from NHIFA data for statutory health insurance [288-295], HCSO and Ministry of Welfare data for private out-of-pocket payments [260; 253; 76; 261; 313-315; 254; 316; 255; 317; 256; 173; 268; 257; 318; 27; 35; 12; 319-321], Orosz et al [112] and OECD [114] estimates for tax funded services and capital expenditures, and WHO Regional Office for Europe, Health for All Database [107] for trends of total expenditures in the last three years. * WHO Regional Office for Europe, Health for All Database [107], OECD Health Data [115], Orosz et al. [112]

The only conspicuous trend in Table A1.3 is the increase in private sources in the period of health care reform. Between 1992 and 2000, the share of private sources almost doubled. Nevertheless, public financing, and, within that, statutory health insurance has always been dominant. Although the share of statutory health insurance decreased by 11% between 1990, when social insurance financing began to operate, and 2000, these trends should be interpreted cautiously. Apart from the divergent estimates for informal payment and general tax sources, mentioned before, the separation between the HIF and national government sources is not watertight. The national government is obliged to cover the deficit incurred by the HIF, and it is debatable whether the hypothecated health care tax is a tax or statutory health insurance contribution. For the sake of simplicity, Table A1.3 makes the assumption that all expenditures of the NHIFA can be considered statutory health insurance. Moreover, it should be noted that reform measures could change the share of financial sources and the structure of health expenditures without any effect on overall spending. For instance, emergency ambulance and high cost high-technology services were transferred from the HIF to national government financing in 1998 [2,18(5)c,g; 1,142(2)a,d], and it is expected that depreciation costs will be integrated into HIF financing during the current government [322].

Figure A1.2. Comparison of health care expenditures as % of GDP, 1985-2000

340102 Total health expenditure as % of GDP



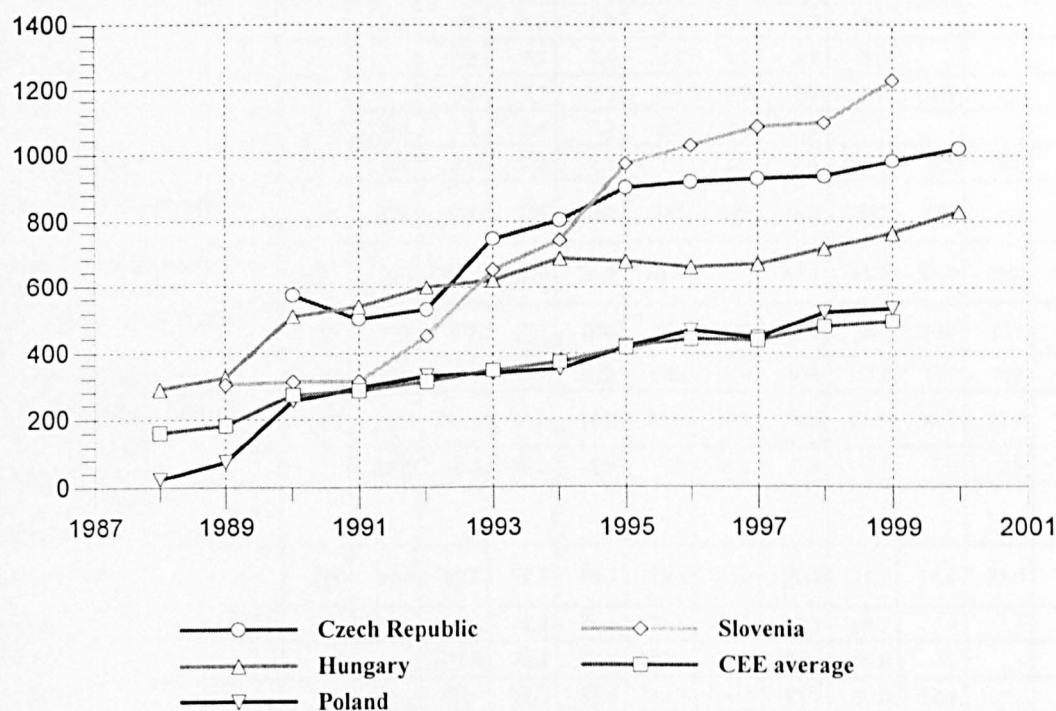
Source: [107]

As far as overall health care expenditures are concerned, Hungary spent more on health care in 1999 than the average for CEE countries by all measures of total health care expenditure, but less than a number of other countries in the region with similar level of economic development, like Slovenia and the Czech Republic, even using the higher estimates of the WHO Health for All Database (Figures A1.2 and A1.3). This

suggests that the country could afford to spend more, especially in the light of the healthy macroeconomic indicators of recent years, but does not do so. Looking at the trends in health care expenditures (Table A1.4, Figures A1.2. and A1.3), we can gain insight into how the country has arrived at the current level of health spending, which, in real terms, is still only at 77% of the 1990 level. Nineteen-ninety was the only year of the past decade when health care spending increased by more than 10% in real terms.

Figure A1.3. Comparison of health care expenditures in PPP USD per capita, 1988-2000

992701 Total health expenditure in PPP\$ per capita



Source: [107]

These figures suggest that successive Hungarian governments during the transition period have implemented a very effective cost containment policy, which ensured that health care spending would not upset the fiscal balance. But it is important to distinguish between two periods. Between 1990 and 1994 Hungary experienced a serious economic recession, and although health care spending was decreasing until 1993, the share of health services in GDP was actually increasing. That is, health services had a larger slice of the shrinking cake. Since 1994, however, GDP has been growing continuously, while health care expenditures have been decreasing or stagnating, not just in real terms, but also as a share of GDP (Table A1.4). Thus, the economic stabilization policies, implemented by the government in 1995 and 1996, have in fact been continued by the next government, at least as far as the health sector is concerned. It has not yet been allowed to enjoy the fruits of economic growth.

The cost containment policies of successive governments have been implemented effectively, but containing overall health care costs does not necessarily imply more efficient resource allocation. While, in general, it is difficult to determine the efficient level of overall health care spending, there are certain benchmarks, such as health expenditures of countries with similar levels of economic development. On this basis it

seems that Hungary might spend more on health care, provided of course that the preferences of the Hungarian population in this respect do not differ much from those in neighbouring countries (see Figures A1.2 and A1.3 for comparison with the Czech Republic and Slovenia).

Table A1.4. Trends in health care expenditures in Hungary, 1989-2000

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Share of GDP (%)												
WHO [116]	5.2	6.1	7.3	7.8	7.8	8.2	7.6	7.2	6.9	6.8	-	-
WHO [107]	5.2	6.1	7.2	7.7	7.7	8.2	7.5	7.1	6.8	6.8	6.8	6.8
OECD [113]	...	6.1	6.6	7.2	6.8	7.3	7.1	6.7	6.5	-	-	-
OECD [114]	...	...	6.8	7.2	7.4	7.9	7.1	6.8	6.4	...	-	-
OECD [115]	...	...	7.1	7.7	7.7	8.3	7.5	7.2	7.0	6.8	...	...
WB [112]	5.7	6.3	7.3	7.6	7.7	8.3	7.8	7.5	-	-	-	-
Share of GDP (%)*	5.4	6.1	6.9	7.2	7.2	7.7	7.0	6.6	6.3	6.3	6.3	6.3
Value in current prices (billion HUF)*	93	128	178	216	268	354	408	464	542	639	717	821
Real value applying health care deflator (1990 = 100)*	92.1	100	97.1	76.6	76.9	84.5	74.1	67.4	66.5	67.4	68.2	71.0
Value in current prices (billion HUF)**	90	128	178	222	276	358	421	490	581	686	775	889
Value PPPS per capita**	325	510	539	601	623	686	678	663	672	717	767	830
Real value applying health care deflator (1990 = 100)**	88.9	100	97.1	78.3	78.9	85.1	76.2	70.8	71.0	72.1	73.4	76.6
Change per year (%)**	-	12.5	-2.9	-19.3	0.7	7.8	-10.5	-7.1	0.3	1.6	1.8	4.3
Public as share of total expenditure on health care (%)												
WHO [116; 107]	100	100	80.8	79.1	79.4	80.0	76.2	76.5	75.3	76.5	75.0	73.5
OECD [113]	...	...	...	91.9	71.1	71.1	69.8	69.3	69.1	-	-	-
OECD [114]	...	...	95.6	94.4	91.9	92.4	88.7	86.8	85.9	...	-	-
OECD [115]	...	...	90.1	88.3	87.0	86.7	84.0	81.9	80.0	82.4	...	...
WB [112]	86.0	85.7	87.7	88.2	87.0	86.7	83.3	82.7	-	-	-	-
Public as share of total expenditure on health care (%)**	91.1	...	92.5	91.1	90.5	90.9	88.8	86.4	87.8	87.7	85.7	82.6

Source: WHO Regional Office for Europe, *Health for All Database* [116; 107], OECD *Health Data* [113; 115], OECD [114], Orosz et al, [112]. *Calculated from NHIFA data for statutory health insurance [288-295], Hungarian Central Statistical Office data for private out-of-pocket payments (1, 9, 18, 19, 20, 27, 28, 29, 30, 31), HCSO and Ministry of Welfare data for private out-of-pocket payments [260; 253; 76; 261; 313-315; 254; 316; 255; 317; 256; 173; 268; 257; 318; 27; 35; 12; 319-321], Orosz et al [112] and OECD [114]) estimates for tax funded services and capital expenditures, and WHO Regional Office for Europe, *Health for All Database* [107] for trends of total expenditures in the last three years. **WHO Regional Office for Europe *Health for All Database* [107]

More importantly, however, cost containment, in itself, does not ensure efficient resource allocation within the health sector. For instance, if patients are treated in hospitals for a condition that could be treated equally effectively, but more cheaply, in the outpatient specialist or primary care setting, resources are wasted. It is difficult to assess these kinds of inefficiencies from aggregate spending data, but the expenditures of the HIF could be used as a crude proxy for this. The trends of expenditures by categories show that financial resource allocation among the various types of health care services has not changed substantially (Table A1.5). Primary, secondary and tertiary care services exhibit a fairly constant share between 1993 and 2000, except for minor changes, which can partly be attributed to known changes in the envelope of HIF financing. Within inpatient care, the share of expenditure for acute and chronic care has remained stable, despite government intentions to expand long term care and to reduce acute inpatient provision [37; 38]. Nevertheless this analysis is limited by the fact that

HIF expenditures are only a partial measure of resource use since only recurrent costs of services are covered by the NHIFA. Capital expenditures are financed directly from the national and local government budget. The latter is difficult to estimate, since there are no official statistics published in Hungary that bring together national and local government expenditures on health.

Table A1.5. Expenditures of the Health Insurance Fund, 1990-2000

Expenditure category	1990*	1991*	1992*	1993	1994	1995	1996	1997	1998	1999	2000
Total expenditure on health care (current prices billion HUF)	99.8	134.5	159.7	192.5	251.9	287.0	341.6	407.4	479.8	523.2	573.4
Administration (%)**	2.9	3.2	2.2	2.9	4.2	3.9	4.5	4.3	4.4	3.7	3.0
In-kind benefits (%)	97.1	96.8	97.8	97.1	95.8	96.1	95.5	95.7	95.6	96.3	97.0
In-kind benefits (current prices billion HUF)	96.9	130.2	156	186.9	241.4	275.7	326.1	389.9	458.5	504.1	556.0
Curative & preventive services (%)	70.4	68.5	71.8	70.4	70.2	69.3	68.9	68.7	65.2	67.2	67.6
Medicines (%)	26.7	28.2	25.2	26.5	25.8	25.7	26.2	25.9	29.6	27.7	27.1
Medical aids (%)	1.8	2.1	2.3	2.5	3.0	3.9	3.7	4.3	4.3	4.1	4.1
Balneotherapy (%)***	...	...	...	...	0.3	0.4	0.4	0.4	0.4	0.5	0.6
Travelling subsidy (%)	1.1	1.2	0.7	0.6	0.6	0.6	0.7	0.7	0.5	0.5	0.6
Other in-kind benefits (%)***	...	...	...	...	0.2	0.2	0.2	0.2	0.3	0.2	0.2
Curative and preventive services (current prices billion HUF)	68.3	89.2	112.1	131.6	169.4	191.0	224.8	268.0	299.1	338.9	376.1
Primary Care (%)	...	...	...	...	18.5	16.6	15.9	15.7	16.0	15.4	14.7
family doctor services (%)	...	...	...	...	11.6	10.6	11.1	10.7	11.0	10.4	9.7
dental care, MCH, other (%)	...	...	...	...	6.8	5.9	4.8	4.9	5.0	5.2	5.0
Out-patient specialist care (%)	...	...	...	...	15.2	17.5	15.8	15.6	16.0	15.9	15.9
Dialysis (%)	...	...	...	...	1.51	1.99	2.42	2.53	2.50	2.58	2.70
CT, MRI (%)	...	...	...	...	-	-	2.07	2.02	2.08	1.91	1.88
Home care (%)	...	...	...	...	-	-	0.01	0.18	0.33	0.33	0.34
In-patient services	...	...	...	...	57.1	58.6	59.4	58.6	61.5	62.2	59.0
acute care (%)	...	...	...	...	49.3	50.7	51.6	50.5	53.3	53.8	50.8
special (%)	...	...	...	...	1.5	1.8	1.7	2.1	1.9	2.1	2.1
chronic care (%)	...	...	...	...	6.3	6.0	6.1	6.0	6.3	6.3	6.1
Other (%)	...	...	...	...	7.7	5.4	4.3	5.4	1.5	1.5	5.4
Total Health Insurance Fund expenditure (current prices billion HUF)	*	*	252.0	303.6	359.9	405.2	463.6	549.2	629.4	698.0	794.4
Cash benefits (%)	*	*	36.6	36.6	30.0	29.2	26.3	25.8	23.8	25.0	27.8
Deficit of the Health Insurance Fund (%)	*	*	8.6	8.5	5.0	5.5	9.4	10.2	11.3	6.8	8.0

Note: *Expenditures of the Social Insurance Fund; cannot be separated in 1990 and 1991. **Only operational expenses included.
***Between 1990 and 1993 included in curative and preventive services.

Source: NHIFA [288-295]

A.1.3.2. Service delivery

Health care delivery in Hungary is based on the constitutional obligation of the state to make health services available for all citizens [22,70/D(1-2),18, 35(1)g]. The delivery system is organized on the basis of the principle of 'territorial supply obligation', with provision by local governments, distributed according to geographical areas and levels of care [43,8(4),70(b); 129,132(1); 139; 1,152-153; 310]. The basic principle is that municipalities are responsible for providing primary care and county governments to provide specialist care for their resident population [the principle of 'principal division of tasks', 43,8(4),70(b)]. In addition to the 'principal division of tasks', municipalities are allowed to provide specialist in- and outpatient care if the majority of the users of the health care institution concerned are residents of the municipality concerned and if

they are willing and able to do so, which the county government must accept according to the principle of 'subsidiarity' [43,69(2-6)].

In practice catchment populations of health care providers in the frame of the territorial supply obligation vary with different levels of care, types of services and the level of specialisation of the institution (the so-called 'progressivity level') [1,75(3),76,92(1)]. For instance, some municipal hospitals provide secondary care for not just the inhabitants of the municipality concerned, but also for the neighbouring population, or some large county hospitals provide tertiary care for the population of two or more counties.

However, to understand fully how the delivery system operates in Hungary, two other distinctions have to be made. First, the principle of territorial supply obligation does not include any obligation for local government to actually deliver health services. They are allowed to contract out service delivery to private providers, which is in fact the dominant form of production for family doctors services [130]. In contrast, the principle of territorial supply obligation does imply another responsibility, the so-called 'maintenance obligation', which rests with the owners of health care facilities [1,155(2)]. The owners of those facilities, whether private or public, that provide services under territorial supply obligation, are required to find sufficient capital funds to maintain the assets in good condition. This principle is especially relevant in those cases where a local government contracts out service provision to a private provider, who delivers the services in a facility that is still owned by local government. This scheme is referred to as 'functional privatization', which is the most common model in primary care [35,16.5,p.370].

Since 1990, local governments have been responsible for the provision of the majority of health services, and they have been delivering the bulk of specialist care too, as the ownership of most hospitals and polyclinics was transferred to local governments in 1990 [43,107(1)c]. The scope of provision, in terms of primary, secondary and tertiary care, is defined by *Act CLIV of 1997 on Health and Act XXXIV of 2001* [1,75-92; 310]. There are, however, some services that are the responsibility of national government, including for instance public health, emergency ambulance services and blood supply [1,35-74,94-96,223-227,142(2)], and the government still owns a limited number of health care providers (e.g. national institutes of health, university medical schools, sectorial services, sanatoria) [e.g.132].

Primary health care

Within primary care, local governments must ensure availability of (a) family physician and family paediatrician services (together referred to as family doctor services), (b) dental care, (c) out of surgery hours services (d) mother and child health nurse services (MCH), and (e) school health services [1,152(1)].

Local governments have the right to designate the primary care districts for family doctor services within their territory [1,152(2)], providing they have more than 1200 adults (for family physician services) and 600 children under 14 years, (for family paediatrician services) [120,8(2-3)]. Primary care districts must cover the entire territory of the municipality, and serve as the basis of the territorial supply obligation. This does not mean, however, that residents have to register with the provider in the primary care district, where they live. Since 1992 people have been allowed free choice

of family doctor, with the only restriction that they can change once a year [161,2]. Doctors are also able to refuse to accept new applicants, except those who live in their primary care district [323,13/B(3)].

Municipalities can also decide whether to deliver family doctor services themselves or contract it out to private providers. Consequently family doctors have four options for employment. First, the municipality can employ family doctors on a monthly salary. Second, under the functional privatization scheme, family doctors, as private providers, contract with the municipality to provide services for the population of a primary care district, but work in a surgery using equipment owned by local government. The family doctor is then paid an adjusted capitation fee directly from the HIF to cover recurrent expenses, while the municipality remains responsible for capital costs, according to the principle of 'maintenance obligation'. Third, family doctors can work as independent private providers with no municipal contract and no territorial supply obligation, if patients choose them, but they are only entitled to capitation payment from the HIF, if they have minimum of 200 registered persons on their list [120,9(1)a]. Fourth, employment options were widened in 2001, with the introduction of the so-called 'freelance' physician status, which removes doctors from public employment regulations, but does not make them self-employed private entrepreneurs [130]. It must be noted, however, that this option is open to specialists as well. In 2000, there were 5,159 family physicians and 1,570 family paediatricians in Hungary, which made the average practice size 1,943, and 952 respectively [12,9.5,9.6].

Beyond family doctor services, municipalities are also obliged to provide district mother and child health services (MCH) and school health services. The District MCH Service, which dates back to the communist regime, is staffed by highly qualified MCH nurses, trained to college level. They provide preventive care and health education for expectant and recently delivered mothers and children under 16 in geographic areas determined by local governments and together with medical doctors they provide preventive health services in nurseries and schools for toddlers and pupils, between the age of 3 and 18 [324; 325].

In general, patients need a referral from a family physician to utilize specialist care [2,13(a),18(1)]. The exceptions are dermatology, ear, nose and throat diseases, obstetrics and gynaecology, general surgery, traumatology, ophthalmology, oncology, urology and psychiatric outpatient care, including dispensaries [131,2,3-5]. Gate-keeping is not effective because there is no incentive in the system to avoid unnecessary referrals [12,9.5; 35,3.2].

Specialist outpatient and inpatient care

The provision of secondary and tertiary care is shared between municipalities, county governments, national government and, to a minor extent, private providers. According to the aforementioned principal division of tasks between county and municipal governments, only county governments are responsible for the provision of secondary and tertiary care for the local population [43,70(b)]. In practice, however, municipalities also provide specialist care, on the basis of the principle of 'subsidiarity' [43,69(2-6)].

By and large, municipalities own independent, multi-speciality ambulatory institutions ('polyclinics', which provide outpatient specialist care), single-specialty

ambulatory institutions ('dispensaries', which provide outpatient care for chronic diseases), and multi-specialist municipal hospitals (which provide secondary acute and chronic, inpatient and outpatient care). Hospitals may provide ambulatory care on the premises, or in a separate polyclinic that is organisationally integrated into the hospital. County governments own large, multi-specialty county hospitals, which provide secondary and tertiary, acute and chronic, inpatient and outpatient care.

The national government also owns some hospitals providing acute and chronic, inpatient and outpatient care. These are divided between various ministries. The Ministries of Defence, of Internal Affairs, of Transport, Communication and Water Management, and of Justice all have special sectoral services, which are largely integrated into the main system of financing and service delivery [e.g.326; 327; 328]. For instance, the Ministry of Transport maintains the Railway Health Service, which is open to all those who are insured, with the proviso that employees and pensioners of the Hungarian State Railways are given priority [327,3(2)]. The Ministry of Education owns universities, which have medical faculties within which single-speciality clinical departments provide both secondary and tertiary care [136,116]. The Ministry of Health has single specialty providers, the so-called 'national institutes of health', which typically provide highly specialized tertiary care only, but also owns so-called 'state hospitals', which are mainly sanatoria, providing medical rehabilitation [132].

The territorial supply obligation applies to all public (and contracted private) providers, but the size of the catchment area depends on the type of care provided, and the number of people affected, not on the institution. In general, secondary outpatient services have the smallest catchment area, but still larger than primary care districts, and highly specialized tertiary care services, which are provided to patients suffering from rare diseases, have the largest catchment area, in some cases the whole country [129,132(1); 139; 1,92(1),152(3); 310].

A small private sector is also involved in the provision of specialist care, but usually with no contract with the NHIFA, so those using it must pay out-of-pocket. The only exceptions so far have been hospitals owned by churches or charities, but these are treated similarly to public providers in relation to the territorial supply obligation and consequently entitled to public funding [35,8.2; 329], and private for-profit provides of certain special services, where there is a lack of public capacity, such as renal dialysis and magnetic resonance imaging.

According to the aforementioned provider typology, outpatient specialist services are provided by polyclinics, dispensaries, municipal hospitals, county hospitals, clinical departments of universities, national institutes, health care institutions of other ministries and of few private owners. Independent polyclinics employ specialist medical doctors, who work exclusively in outpatient care, while dispensaries were established by the communist regime to provide chronic outpatient care for pulmonary diseases, skin and sexually transmitted diseases, alcohol and drug addicts and psychiatric disorders. In addition to care for the chronically ill, dispensaries implement screening programmes, for example for hypertension, diabetes, cancer and kidney diseases. In 1999 there were 162 pulmonary, 122 dermato-venereal, 139 psychiatric and 136 addiction dispensaries [318,5].

In 2000, inpatient care in Hungary was provided in 178 hospitals, with 83,430 beds [12,9.9]. These hospitals, by and large, provide in patient care at three levels: (a) municipal (local) level, (b) county level and (c) regional or national level. This

indicates the level of specialization of the hospital, the so-called 'progressivity' level, which, in general, coincides with the hospital catchment area. However, hospitals that provide care in more than one medical specialty, can have different progressivity levels for different specialities and consequently different catchment areas. Moreover, a hospital can have different catchment areas for the same specialization. For instance, clinical departments of university medical faculties have a local catchment area for secondary care, and national catchment area for tertiary care services within the same medical speciality.

The utilisation principle of the health care delivery system (the so-called 'progressivity principle') is that patients must receive care at a provider with the lowest possible level of progressivity that can provide adequate treatment, and must be transferred to hospitals with higher levels of progressivity only if the problem cannot be solved in the health care institution with lower progressivity level [1,75(3),76]. Where a patient ends up in the hospital system, in principle, depends on the frequency of the disease, the severity or complexity of the case, and the cost and complexity of the available and required therapy.

Municipal hospitals usually offer main specialities, such as internal medicine, obstetrics and gynaecology and surgery [330,1(2)b-ba]. They have the lowest level of progressivity and the smallest catchment area. County hospitals constitute the next level of inpatient care [330,1(2)b-bb]. They usually cover the whole spectrum of secondary care, providing additional specializations, like haematology, immunology, cardiology and psychiatry for the population of an entire county. For the basic specialities county hospitals usually have a local catchment area with the lowest level of progressivity and accept more severe or complex cases from municipal hospitals as the second level of progressivity with a catchment area being a whole county. They may also provide tertiary care, like open heart surgery, for the population of a region (comprising more than one county). Finally, clinical departments of university medical faculties and national institutes provide care of the highest level of progressivity with the catchment area of the whole country, but as it has been mentioned before, university clinical departments also have local catchment areas [330,1(2)b-bb].

In 2000, university clinical departments had 9.5% of the total number of beds, national institutes had 7.2%, local governments had 76.7% (with 14.9% in the capital), the health care institutions of Railway Health Service had 1.9%, the Ministry of Internal Affairs and the Ministry of Defence had 2.7%, while 2% were privately owned by churches and charities [12,9.11; 35,8.2].

Public health services

The central institution of public hygiene, occupational health, communicable disease control and health promotion is the National Public Health and Medical Officer Service of the Ministry of Health, or NPHMOS for short [331,1(1-3),2-5; 1,151]. The NPHMOS is organized on a regional basis with central (national) organs, county offices and local (municipal) offices [331,7-8; 332,1-2].

The NPHMOS is responsible for the control, coordination, supervision and delivery of public health services, but services are delivered in cooperation with other agencies [331,2(4),4(4)d,5(1); 332]. For instance, the NPHMOS coordinates the compulsory immunization program and supplies the vaccines, while family physicians and

paediatricians, and the school health service vaccinate the children [325,Annex 2(3,a), Annex 3(5); 333,4(2),5(7-8),15,16(1)a-b,16(2)a,16(3)a]. The district MCH service provides pre- and postnatal care, prevention and health education, while it is coordinated and supervised by senior MCH nurses of the NPHMOS [324; 332,4(3)]. The NPHMOS also carries out a number of health administration duties, such as registration and professional supervision of health care providers [331,6; 334; 148; 335].

Social care and social assistance

Social care organisation adheres to the same principles as health care [138]. In general, the poor and the disabled are eligible for social assistance and social care, including cash and in-kind benefits. The two main health care related in-kind benefits for the poor are the pharmaceutical co-payment exemption and the eligibility for health care for socially indigent people, who otherwise would be excluded from statutory health insurance, such as the long term unemployed, unregistered workers and the homeless [138,49-54; 336; 337]. In kind benefits for the disabled include primary social care, which is provided in the home of the disabled person (catering, domestic help and family help) [138,59-65], and specialist social care, which is provided by institutions for the elderly, the physically and mentally handicapped, drug addicts and the homeless in the form of long-term residential care, rehabilitation, day care or transitory (short-term) institutional care [138,66-85/C]. There has been a chronic shortage of institutional places with around 20 persons on waiting lists per 10,000 population since 1993 [12,8.23].

Human resources

Hungary had 3.6 medical doctors per 1,000 population in 1999, which is in the top third of countries of the WHO European Region. In contrast, the number of nurses was 3.7 per 1,000, which was among the lowest. Thus, the ratio of doctors to nurses is especially far out of line with other countries [107]. Furthermore, average figures hide geographical inequalities, as well as inequalities in terms of specialities. Ignoring counties with medical universities, the average number of practicing physicians was the lowest in Szabolcs-Szatmár-Bereg county with 2.2 per 1000 population, and the highest in Vas county with 3.1 in 1999 [318,16.9]. From the 33,308 available medical posts in the public sector, 9.3% were unfilled in 1999, which implies not just regional differences, but differences between specialities. For instance, there was a shortage of public health doctors with 19% of the available posts unfilled, but also in inpatient care, where the corresponding figure was 13%. In contrast 99% of family physician and family paediatrician primary care districts were filled in 1999 [318,16.6].

The training of health care professionals takes place within a well established institutional framework, which provides courses at secondary, post-secondary and higher education levels. The first higher education qualification is free of charge for Hungarian citizens, but the number of publicly funded students admitted is regulated by quotas [137].

Pharmaceuticals

The vast majority of the pharmaceutical industry has already been privatised from production to retail sales, trading has been liberalized and the whole supply chain is comprehensively regulated [338; 339; 183; 340; 341; 142]. The registration and licensing system is operated by the National Institute of Pharmacy of the MOH [143]. Licensed pharmaceutical products have to be on the national drug list to be eligible for insurance subsidy [131,7-10]. Annual price negotiations between pharmaceutical companies, wholesalers, retailers and the representatives of the government (MOH, Ministry of Finance, NHIFA) determine the national drug list, and approve the consumer price, price margins and the extent of subsidy for each product [131,10/A; 342]. A more restricted list of pharmaceuticals is also established for products that can be prescribed without co-payment [337]. Patients require a valid prescription from an authorized physician to purchase the medicine at the subsidized price [340]. Prescribing is monitored by the county branches of NHIFA [2,36(4),37(4-6),38].

A.1.3.3. Governance, planning and regulation

Despite early decentralisation measures, national government has retained a central role in resource allocation decisions within the health sector. Between 1993 and 1998, the purchasing organisation, the NHIFA was controlled by a quasi public body, the Health Insurance Self Government, which comprised representatives of employees and employers, with extensive veto rights on budgetary decisions [343-345]. Later the government saw the Health Insurance Self Government as a potential threat to cost containment efforts and curtailed these rights [176; 177] and finally it was abolished all together [133]. Since then all aspects of the purchasing function have been centralised, including revenue collection, budget setting, financial resource allocation, contracting and payment, but these tools have rarely been used so far beyond broad cost containment efforts, for options such as selective purchasing [119,19; 2,34,35; 120-122]. Capacity has been addressed through the contracting process [139], although responsibility for planning local health needs has remained with local governments [43; 129]. As of 1 January 2002, local governments have enjoyed somewhat more flexibility to decide on service provision, since the national government has repealed the *1996 Capacity Act* [310]. Local governments still have the obligation to provide capacities at the level in 2001, but they are allowed to decrease and restructure facilities according to local priorities, if these decisions are approved by the county chief medical officer of the NPHMOS [310,2,4]. They can even expand local health care provision, but any extension must be approved by the Minister of Health and the Minister of Finance [310,3(2)].

Nevertheless, the national government does not directly determine the inputs or outputs of the health sector (the formal central planning system of the previous regime was abolished), but does influence them through its regulatory function.

Regulations apply to all aspects of the production process. Health care inputs, including human resources [140; 141], pharmaceuticals, medical devices and health care facilities fall under registration and licensing systems [142-148] and price regulations apply to publicly employed health workers, pharmaceuticals and medical aids and prosthesis. The minimum salary of public employees is set according to a national pay scale [128], whilst pharmaceutical price regulations include the wholesale and retail

price margins, as well as the consumer price, but these regulations does not apply to pharmaceuticals purchased by health care providers [184; 183; 346]. The number of health personnel is controlled by determining the number of students financed from the government budget [137], and by regulation of the recognition of foreign diplomas [136,105-109; 141,6(1)]. Since 2000 the number of primary care practices is also regulated through the institution of the 'practice right' [185; 347]. The practice right was granted to all practising family doctors with territorial supply obligation, and it can be sold to newcomers by existing practitioners who choose to stop practising. An incoming family doctor must purchase a right to establish a practice. The behaviour of health care workers is also regulated, including rights and duties and ethical considerations [157; 166; 165; 1,125-140].

Providers must obtain a licence to practice from the NPHMOS, which maintains a registration database [334; 148]. Before issuing the licence to any provider, medical officers inspect the facilities and ascertain whether the minimal building, hygienic requirements, personnel and material standards are fulfilled, set by *Decree No. 21/1998. (VI. 3.) NM of the Minister of Welfare* [348; 349; 330]. Specific rules apply to a number of services, such as family doctor services [347], home care [350], patient transfer [351], emergency ambulance services [352], human fertility treatment [353], sterilization procedures [354] and organ transplantation [355]. The provision of non-conventional medical treatment is also regulated including its scope, educational, infrastructure and administration requirements [356]. All health care providers are obliged to take out liability insurance [1,108(2)]. These minimum standards are monitored by the NPHMOS, but the system of professional supervision includes quality control of services as well [335].

Patient rights are regulated extensively in the *1997 Health Act*, which has established institutions for the safeguarding of these rights and resolving disputes, namely the patient rights representative and the arbitration [1,6-25,28-34; 149-151].

A.1.4. SUMMARY

The Hungarian health care system was transformed from an integrated model into a contract system, in which purchasers and providers are separated. The system is contract based in which purchasing and service delivery, as well as responsibility for service provision and service delivery are separated. Despite large scale decentralization measures and privatization efforts, the Hungarian health care system is still predominantly publicly financed and provided. In the current setting, the single, most important monopsonistic purchaser, the NHIFA contracts with health care providers, owned mainly by local governments. Providers are reimbursed chiefly on the basis of outputs produced.

A.2. Evolution of the Hungarian health care system

This section provides background information on informal payments from a historical perspective. It traces the evolution of the Hungarian health care system from the pre-war period through the crisis of the state-socialist system to the stage of health care

reform that was initiated in the last years of the communist dictatorship,⁶⁰ and it closes with a brief account of the history of informal payment, exploring successive government policies and the academic perspectives that have been brought to bear on it.

As we have briefly discussed in chapter 1, the twentieth century was a particularly stormy period in Hungarian history. After the First World War Hungary lost two thirds of its territory and one third of its population, and the Second World War resulted in a loss of sovereignty. Nevertheless, the end of the 1980s has witnessed the collapse of the communist regime in the CEE region and given hope that Hungary will be able to catch up with the established market economies of Western Europe. The serious legacy left by the previous regime, however, has proved a hard challenge to face, especially in the case of the health sector. Reform efforts that aimed to overcome the failures of the Semashko system, proved ineffective in eliminating informal payments.

A.2.1. HISTORICAL ROOTS: THE HEALTH CARE SYSTEM BEFORE WORLD WAR II

Before the Second World War the Hungarian health care system was characterised by a mix of public and private sectors both in terms of financing and service delivery [49; 153; 152]. The role of insurance, both the Bismarck-type social insurance and private insurance, was increasing dynamically [152,pp.31,37]. Physicians could be in private practice or be employees of public or private insurance companies or hospitals, but frequently they combined these options [49,pp.36-37; 154; 73].

Ádám [50; 49,pp.19-61] gives a detailed description of the situation of physicians in the pre-war period, from which the following points emerge. Before the emergence of health insurance, medical practice was typically private and patients paid the fee out-of-pocket, which was subject to negotiation between the patient and the physician. Physicians usually charged patients according to their perceived ability to pay, and the poor, who held a certificate from the authorities, could utilise so-called 'free surgeries', where they did not have to pay at all. Price setting in private practice and 'free surgeries', however, became a source of continuous debate within the medical profession to ensure 'fair' competition between individual providers. The National Physician Association, which was founded in 1897, and later the National Medical Chamber, enacted in 1936, argued that under-charging to attract patients was unethical because physicians who started price competition actually sacrificed part of the producer surplus to maximise their own income at the expense of others. Hence, during this period a compulsory minimum fee was set [49,pp.27-28,50-51,53]. In a similar fashion, 'free surgeries' were seen as a marketing tool to attract patients to private practice, so 'free surgeries' were subject to strict regulations that sought to ensure that physicians, as well as patients who otherwise would have been able to pay for the service, could not benefit from them. For instance, physicians were banned from attending patients without a certificate of poverty except in emergencies, they were not allowed to undertake charitable collections, and the name of the physician(s) could not be displayed in the surgery [49,pp.44-47,51-52]. Ádám [49,pp.49-50] argued that the pre-war period was characterised by an increasing number of physicians but a limited

⁶⁰ For a more extended discussion of health care reform in Hungary, see the Health Care Systems in Transition series of the European Observatory on Health Care Systems (Gaál et al. [11] and Gaál: Health Care System in Transition: Hungary. Copenhagen: European Observatory on Health Care Systems [29]).

capacity of the population to pay, which sharpened competition between individual providers. Thus, the various physicians' organisations acted to protect private practice and to prevent 'unfair' competition ('fair', as mentioned before, in this respect virtually meant price discrimination to maximise income from private practice). Nevertheless, even patients who were considered solvent sometimes were reluctant to pay the negotiated fee, delayed payments or even did not pay at all [49,p.44]. Ádám [49,pp.59-60] found that during this period physicians circulated so-called 'black lists', which contained the names of notorious non-paying patients, who were not attended except in emergencies. These black lists re-emerged after the Second World War, during the period that preceded the establishment of the state-socialist health care system [49,p.75].

The situation was further complicated by the rapid growth of health insurance [50; 49; 152]. By the 1930s, approximately one third of the population was insured [152,p.39]. Both public and private insurance companies employed physicians who attended insured patients. Of course, the medical profession had increasingly seen health insurance as a new source of 'unfair' competition. First, health insurance deprived private practice of an increasing number of solvent patients, and second insurance companies had a considerable market power to buy the labour of doctors at a depressed price [49,pp.34-43]. Not surprisingly, the National Physician Association fought against the so-called 'bound doctor system', which as Bíró argued [cited in 49,pp.38-39], was not good either for the patient or the doctor:

"...the patients, because they cannot choose their physician, the physicians, who do not work for insurance companies, because they have almost no private practice... and those, who work for the insurance companies, because worrying for their 'dry' bread, tolerate that insurance companies exploiting their labour without remorse, in exchange for humiliatingly low salaries".

They argued that health insurance should have been open to those who were really unable to pay for care [49,p.38]. However, if solvent patients were included, patients should be allowed to choose their doctor freely and physicians should be allowed to negotiate additional fees, which was in fact the case concerning private health insurance [50,p.64; 49,pp.78-79]. *"The fight between illness insurance companies and our medical profession is almost as old as these institutions are themselves"* Mihálikovics, the chief secretary of the National Physicians Association said in his speech at a congress in 1932 [cited in 49,p.40]. But *"Everything depends on that whether the socialized medical doctor [physicians working for insurance companies] receives in exchange for her work, what she is entitled to"* [7; cited in 49,pp.10-11].

Ádám [49,pp.56-61] reached the conclusion that the pre-war history of the Hungarian health care system revolved around these issues, but there was not a single reference to informal payment, or even tipping in health services. Nevertheless, the evolution of the health sector in this period raised interesting dilemmas that are relevant to the discussion of the causes of informal payment. Most notably, the debate between insurance companies and physicians on the appropriate level of payment resembles the continuous debate between the government and the union of health workers about low salaries during the communist dictatorship (this issue was explored in the discussion on informal payment in chapter 4).

A.2.2. THE STATE-SOCIALIST HEALTH CARE SYSTEM AND ITS CRISIS

After World War II the earlier development of the system was disrupted by the forced introduction of the state-socialist 'Semashko' model [153]. After a relatively short transition period between 1945 and 1949, the communist party (at that time called the Hungarian Workers Party) took exclusive power backed by Soviet weapons. The state assumed responsibility for health insurance, nationalised the provider institutions and medical doctors became state employees [155; 156]. While private financing was limited to out-of-pocket payments as private health insurance was eradicated, private medical practice was not totally forbidden. All physicians had to have a full-time public employment, but they were allowed to have part-time private practice after official working hours [157,39(2)b]. Population coverage was increased in large increments. In 1949 41%, in 1957 62%, in 1960 85%, and in 1965 97% of the population was covered [197; 50]. Finally *Act II of 1972 on Health* declared access to health care as a right linked to citizenship [252,25(1); 357,354(2); 358]. The system promised comprehensive, high quality care free of charge to each citizen, but an increasing gap had developed between rhetoric and reality [40; 39; 153].

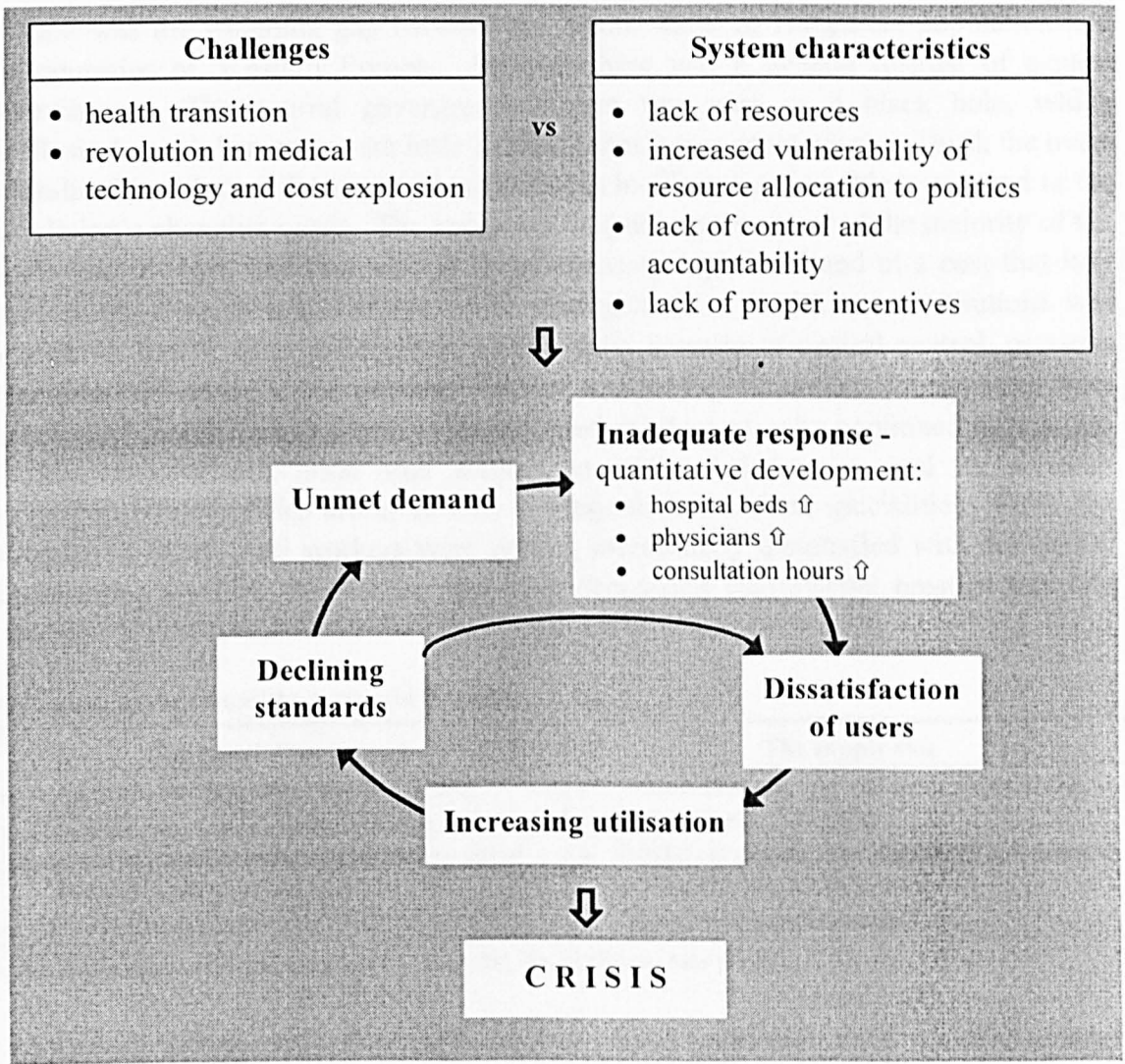
As has been discussed before, the early Shemasko system had provided substantial improvement in the health status of the population through the control of infectious diseases. Nonetheless it was unable to respond adequately to the revolution in medical technology and the health transition of the population, when non-communicable diseases began to dominate mortality [158; 40]. Despite its ambitious objectives, in the communist regime health services were regarded as an unproductive sector of the economy, with low priority in resource allocation decisions [70]. Health workers, especially physicians, were kept on a low salary, which became a source of ongoing policy debate [50; 49; 8; 67]. Historical line item budgeting and salaries did not reward better performance and conveyed no incentive for efficient utilization of resources [52]. Moreover, managers of health care provider institutions were predominantly physicians, who saw management positions as an opportunity to favour their own specialities by influencing resource allocation inside their institutions, while they kept on practising. The paradox of the state-socialist health care system was that not only was the government unaccountable and unresponsive to the public, but the highly centralised government lost control in ways that exposed resource allocation to political influence [109; 39; 153]. As Orosz [39] put it, the system was highly centralised to keep strong control, but in fact it lost control over the actual processes.

The Semashko system reacted to the changing needs by the inflation of input targets, which led to the development of excess capacities, whilst patients wanted not more, but better care. As Bordás [52] put it, the challenges of the 1970s and 1980s created a shortage of quality not quantity. Tensions were further aggravated by the influence of politics on the budget setting process, which created regional inequalities in service provision, as well as inequalities in terms of medical specialities [40; 159; 71; 153; 39]. Generally speaking, these were manifested in unequal standards of care, rather than access to care per se. Moreover, as Ádám [50] pointed out, the initial tipping of health workers, which emerged in the 1950s, became widespread during this period, and gained legitimacy in the system as gratitude payment.

As a result of these processes, a crisis had gradually developed, but as part of a wider crisis of the 'state-socialist' economic and political system [39]. The crisis was

characterized by excess capacity, deteriorating service quality and widespread informal payment, a mixture of waste and shortages, and inefficiency and unequal access [39; 52; 153]. The latter could have been particularly embarrassing for the regime, which promised comprehensive health care for all citizens, free of charge at the point of use. Moreover, the expanded capacity had quickly been absorbed by increasing utilization with inadequate treatment, which in turn induced further extension of service provision. Szalai [40] hypothesised a vicious circle in the state-socialist health care system, which was getting increasingly difficult to break (Figure A2.1). The mounting tensions in the system called for reforms, which, in Hungary, began in the second half of the 1980s, the so-called reform communist era.

Figure A2.1. The crisis of the Semashko system in Hungary



Source: On the basis of Szalai [40] and Orosz [39]

A.2.3. THE BEGINNING OF HEALTH CARE REFORM⁶¹

Health care reforms in Hungary began in the last years of the communist regime, in the mid 1980s, when the continuously deepening recession of the economy and the increasing pressure from the emerging political opposition allowed a reform-oriented, liberal faction of the communist party to take control of government and formulate policies for the reform of the health care system. The reform communists, in the same way as later freely elected governments, have sought answers to the problems of the state-socialist health care system within a context characterized by poor performance of the economy and massive political, economic and social transition, which the collapse of the communist system initiated (Table A2.1). Health sector reform was motivated by a number of factors.

First was the widening gap between the health status of Hungarian population and the countries of Western Europe. Second, there was a general distrust of central government. The central government budget was seen as a black hole, which swallowed people’s money with little evidence that it was spent wisely. Third, the over-centralised health care delivery system was seen inefficient and unable to respond to the population’s changing needs. The oversized hospital sector absorbed the majority of the health care budget, and care was at an unnecessary high level and at a cost that was increasingly thought unaffordable. The management of health care institutions was considered unable to provide services efficiently, because of central control, perverse incentives embedded in the payment system, and inadequate managerial capacity, with directors of health care institutions mostly medical doctors, who continued to practise. Fourth, resource allocation was subject to political influence, and as a result geographical inequalities arose, as well as inequalities between specialities. Fifth, the majority of health care workers were getting increasingly dissatisfied with the slowly deteriorating working conditions, and their decreasing professional prestige and low salaries.

Table A2.1. The legacy of the Semashko system in Hungary

The population in need	The supply side
<ul style="list-style-type: none">• One of the worst health status in Europe;• Changing and in some areas growing needs of the society further enhanced by the impact of transition process itself;• Dissatisfied patients.	<ul style="list-style-type: none">• Professional and regional inequalities in the provision of health care;• Inefficient system, where shortage and waste were prevailing at the same time;• Dissatisfied health workers.

Source: Summarised on the basis of Szalai [40], Orosz [39], Bordás [52] and Antal [153]

The early reform objectives followed from these problems of the inherited system [36; 37]. Policy makers wanted to increase the efficiency of the system by ensuring secure funding for health care, structural reorganization, with considerable decentralization, aligning incentives, and increased competition with wider consumer choice. Policy makers also wanted to decrease inequalities by improving resource allocation, and to increase the quality of care but at a cost that was affordable. Within the wider context of health, policy makers envisaged a substantial role for health

⁶¹ This section is being published by the European Observatory on Health Care Systems, in the series of Health Care Systems in Transition country profiles (Gaál P: Health Care Systems in Transition: Hungary [29]).

promotion to change the health culture of the population, including enhancing health related lifestyles.

A.2.4. THE PHASES AND PERIODS OF HEALTH CARE REFORM

In the first phase of the reform, until 1994 (i.e. during the period of the first freely elected government of prime minister Antall), most reform measures were implemented as originally devised during the reform communist period, with considerable decentralization (see summary Table A2.2). All this happened in the context of the transformation of the economy, which was characterized by a deep economic recession. Although GDP began to recover in 1994, the state budget deficit prompted restrictive measures. The second phase of the reform was overwhelmed by the economic stabilization efforts of the government of 1994-1998 (i.e. the Horn government), and the goal of cost-containment began to dominate health care policy. Despite the favourable economic climate characterized by impressive and stable economic growth, cost-containment has remained the main policy objective throughout the period of the government of 1998-2002 (i.e. the Orbán government).

Table A2.2. Phases and periods of health care reform in Hungary

Phase	Period	Short description
I. Establishment of the contract model of the Hungarian health care system	1987-1994	Decentralisation
1. The reform communist era	1987-1990	Blueprint for health care reform
2. The ANTALL government	1990-1994	Implemented as planned: the purchaser-provider split is in operation
II. The cost containment era	1994-2002(?)	Recentralisation on the agenda
3. The HORN government	1994-1998	The beginning of the cost containment era: sacrificing health expenditures on the altar of economic stabilisation
4. The ORBÁN government	1998-2002	Searching for the way forward in the context of continued cost containment: the debate on insurance competition
III. The end of cost containment(?)		?
5. The MEDGYESSY government	2002-	

The reform measures implemented so far reflect the disparity between objectives pursued before and after 1994. Before 1994, health sector reform was characterized by decentralization, with the aim of moving away from a failed and distrusted centralized model of integrated health services, and by the end of 1994 the new contract model of health services, in which the purchaser and provider was separated, was operating. It was thought that command and control mechanisms had failed, hence emphasis was put on incentives, such as new payment methods, to produce the necessary structural changes without direct government intervention. After 1994, cost-containment became the utmost priority of government policy, so determining the direction of further reforms. The HIF was increasingly seen as a potential threat to fiscal balance, and efforts were made to restore government control over health care spending and allow direct intervention in the system. This period was characterized not only by fiscal restrictions, but direct government interventions in the delivery system. Nevertheless, the contract model remained unchanged.

The following sections provide a more detailed discussion about the reform process of the past fifteen years, using election cycles, starting with the period before the first free elections in 1990 [41]. Although reform objectives divide health care reform into two distinct phases, within these, each governmental period has its own peculiarities, which distinguish one from the other.

A.2.4.1. The blueprint for health care reform: the reform communist era (second half of the 1980s)

During the second half of the 1980s (reform communist era), under the pressure created by the failures of the Semashko system, the Ministry of Social Affairs and Health established the so-called 'Reform Secretariat' in 1988, which produced policy proposals on the basis of international experiences [36].

The Reform Secretariat considered options from a number of countries. It looked to the USA for the DRG payment method and the concept of Health Maintenance Organizations, which integrated financing and provision; to Germany for autonomous quasi-public owners, a strong ambulatory care system, output based payment of ambulatory care providers, and the three member management (consensus management) of health care institutions; to the Scandinavian countries for health centres, and to England for capitation payment of family physicians [41].

The Ministry launched a number of pilot projects, including the adaptation of the American DRG based hospital payment system. In 1987, the Information Centre for Health Care (IHC, GYÓGYINFOK) was set up, which was responsible for the DRG project, and has been the key player in the design and administration of provider payment methods ever since [359-361].

The proposals of the Reform Secretariat outlined the principles of the new health care system [36; 41]. A key element was that sources of health care financing should be separated from the central government budget, so that revenues could not be used for other purposes. Another key principle was the so-called 'sector neutrality', that is health care financing should not discriminate against private providers. There were intentions to merge polyclinics with inpatient facilities or primary care to make the delivery system 'two-pillar' instead of the three pillars of primary care, polyclinics, and hospitals of the state-socialist health care system. In primary care a family physician treating the whole family, from young to old, was envisaged, and it was planned to amalgamate district paediatricians and adult district physicians system into one service.

The reform communist government successfully implemented some early changes. In 1989 the system was switched from tax-based financing to compulsory social insurance [42]. In 1990, the budget of the health service was transferred to the newly established Social Insurance Fund (SIF) [362]. This was later referred to as the 'fund exchange', since at the same time the budget for child benefits was transferred from the SIF to the central government budget [41]. Since the SIF was meant to cover the recurrent costs of services, funds for capital costs remained in the central government budget. Finally, in 1989, private health care provision was legalized [44; 45].

A.2.4.2. Implemented as planned: the period of the Antall Government (1990-1994)

The Antall government continued the major structural reforms, according to the previous plans. The head of the Reform Secretariat became state secretary in the new

government, which allowed a degree of continuity in health sector reform. Some technocrats, who were working on pilot projects, remained in office, which also provided some stability.

The *1990 Local Government Act* created the provider side of the new contract model [26; 43]. The ownership of primary care surgeries, polyclinics and hospitals was devolved from national to local government along with the responsibility to ensure the supply of health care services to the local population, the so-called 'territorial supply obligation' [43,107(1)c,8(4),70(b); 129,132(1)]. The new owners became responsible for maintenance and investment costs, but central government established the system of 'earmarked and target subsidies' to support local governments with conditional and matching grants [125].

As part of the reform of public health and the modernization of health system administration, the National Public Health and Medical Officer Service (NPHMOS) was established as a state agency in 1991 [331; 332]. The NPHMOS was built on the State Supervision of Public Hygiene and Infectious Diseases (SPHID) of the communist regime and managed to preserve its effective infectious diseases surveillance, immunization and public hygiene functions. The government envisaged a wider role in public health and health promotion, but the Service was constrained by available human resources [331,1(1),3-5]. In addition the Service was assigned the task of professional supervision and coordination of the delivery of health care [331,6,15(4); 335; 348].

The financing system was developed further after a debate on whether to move towards a single- or multi-insurance model [363]. A single-insurance model was accepted, leaving open the option of competition between insurance schemes in the future [363,10]. It was decided that the SIF would be divided into a health and a pension fund, and that both funds would have quasi-public supervision consisting of the representatives of employers and employees [363,12; 343]. Consequently, in 1992, the social insurance contribution was split into a health insurance and pension insurance contribution [296,19(103)], the SIF was divided into the Health Insurance Fund and the Pension Insurance Fund [47], and was made self-governing, after the election of trade union representatives in 1993 [344; 345]. Immediately after the establishment of the Health Insurance Self Government, the administration of the former SIF was also divided into two, and the NHIFA was put under the direct control of the Self Government [118].

Policies to strengthen primary care were implemented gradually. In 1991 the National Institute of Family Medicine was established to coordinate policies to improve professional standards in primary care [160]. In 1992 district physicians were renamed 'family physicians', postgraduate training for general practitioners was made compulsory, and undergraduate training in family medicine for medical students was introduced with new departments in medical universities [161; 162]. People were allowed to choose their family physicians [161], and the system of capitation payment with contracting of family doctor services was introduced [46]. Family doctors were encouraged to become private and contract with local government, with surgeries and equipment still owned by the local government, known as 'functional privatization'. The original plan to abolish district paediatrician service was not, however, implemented [162].

New payment systems for other services were also introduced. Output based payment methods, the FFS points (points for procedures), the HDGs (Homogenous

Disease Groups, the Hungarian version of DRGs) and patient days were coupled with the cost-containment mechanism of capping the sub-budgets of the HIF [47; 163; 122]. This proved to be a very effective tool for cost-containment under successive governments. No real change happened, however, in the remuneration of the health workforce. The act of public employment guaranteed a minimum salary, and although no upper ceiling was determined, salaries remained low in comparison to other sectors [128; 17; 23,4.12,4.16].

At the end of 1993, parliament created a legal framework for the establishment of non-profit health insurance on a complementary basis [164], and in 1994 the Hungarian Medical Chamber and the Hungarian Chamber of Pharmacists began to operate on a self-regulatory basis, with compulsory membership for practising doctors and pharmacists [165; 166].

The government was less cautious concerning the pharmaceutical sector. Pharmaceutical manufacturers, wholesaler and retailers were mostly privatized and the pharmaceutical market was liberalised. It is not surprising, therefore, that rising drug expenditures became one of the most important causes of the HIF's deficit, which continuously puzzled successive governments [e.g.304,Annex 2].

By the end of the first period of government, the foundations of the new model of the Hungarian health care system had been laid down. There was a single monopsonistic purchaser, the NHIFA, that contracted with service providers, mainly in the public but also in a growing private sector with family doctor services and pharmacies. The supervision of the HIF and the control of the purchaser were delegated to the quasi-public Health Insurance Self Government, but many purchasing decisions were made by the national government and the National Assembly, such as budget setting, financial resource allocation and the choice of payment methods. The transition of the economy was well under way, and began to show signs of recovery in 1994. Health workers, however, perhaps with the exception of family doctors, did not feel much improvement in their working conditions, especially in their salary [16]. In 1994, the successor of the communist party was voted back to power, and for more than a year, nothing significant happened in health sector reform [167].

A.2.4.3. The beginning of cost containment: the period of the Horn government (1994-1998)

The first significant measure of the new government in June 1995 was not favourable for the health sector. The government had anticipated an economic crisis as GDP growth slowed down and inflation started to rise again coupled with a substantial state budget deficit (see Table 1.2. and Figure 1.3. in Chapter 1). In this setting the health sector was seen as a potential threat to fiscal balance, and reform measures aimed to achieve the new priority objective of cost-containment. The first economic stabilization package, the so-called 'Bokros package' (named after the minister of finance), was introduced in the middle of 1995 and targeted the welfare provisions of the state, including health services [168; 169]. On the financing side, the health care budget was cut in two consecutive years [170; 171], and in 1997 reached its lowest level in real terms since 1990 (see Table A1.4 in Appendix A.1). Dental services were excluded from HIF coverage, subsidies on spa treatment were removed, and co-payment for patient transport was introduced [168,80,92; 169], but shifting costs to patients was somewhat counterbalanced insofar as the government offered tax rebates for the

purchase of voluntary non-profit health insurance [301,35(2)]. In addition, responsibility for occupational health services was shifted to the employers [172]. The government had also decided to tackle directly the problem of the oversized hospital sector, and assigned the Minister of Welfare to determine the capacities the NHIFA must contract for, in the framework of the territorial supply obligation [170,10(2)]. As a result, approximately 9,000 beds were removed from the system [35,1.5; 173,8.1], although the process of decision making was later found unconstitutional in relation to the rights of local governments and because of the method of decision-making [364].

Seeing the sharp drop in the utilization of the public dental services, the government decided to reintroduce tooth preserving dental services into the benefit package, with some co-payment [171; 365], but this was just a short pause before the next restrictive package. This time the government targeted the revenue side of statutory health insurance and reviewed the scope for continuing to reduce the size of the delivery system.

Given an adverse ruling on the constitutional right of the Minister of Welfare to directly intervene into the delivery system [364], *Act LXIII of 1996* devised a need based formula to determine specialist health care capacities. It is not surprising that the formula called for cuts in hospital beds in most counties, but the decision about which institution should have given up how many beds, was left to the so-called 'county consensus committees' [139,8-9]. It was a wise decision inasmuch as the political unpopularity of hospital closures did not directly fall on the government, but at the same time the government lost the opportunity to achieve really significant savings. In fact, few institutions were closed, partly because it was easier to get agreement for everybody to give up a small number of beds than to close a whole institution, but also because of the political resistance of local communities [33,9.10]. Finally, approximately 9,000 further beds were removed from the system between 1996 and 1997 [35,1.5; 173,8.1]. Another implicit rationalization measure was the introduction of the so-called 'minimum standards' defining a health care institution. By defining minimum standards of personnel, equipment and buildings it was expected that certain substandard health care facilities could eventually be closed down [348]. However, as politicians expected that it might cause mass closures, the deadlines by which health care providers had to meet the requirements was extended twice [349; 330].

The revenue strategy comprised three elements: (a) widening of the social insurance contribution base, (b) decreasing employers' health insurance contribution rates, and (c) the introduction of a lump sum tax, the 'hypothecated health care tax' [174,10; 175]. All these measures aimed to increase the revenue of the HIF by mitigating the evasion of social insurance contributions. Since the establishment of the SIF, underreporting of income and payment in arrears had been widespread, but the social insurance contribution was high, at 54% of gross salary, including 23.5% as the health insurance contribution [296,19; 366,103(1-2),103/A-B; 119,19(1),19(3),24]. It is interesting to note that the government deliberately introduced a new hypothecated tax rather than determining a fixed minimum level of social insurance contribution. The Constitutional Court ruled that several measures in the first economic stabilization package were unconstitutional on the basis that, in an insurance relationship, the parties could not freely modify the terms of the agreement, while there were no such restrictions for tax funded services [367]. Moreover, some analysts viewed this measure as the first step towards the recentralization of the HIF [41]. And indeed, the other main thrust of

measures was to target the Health Insurance Self Government and the output based payment methods of service providers.

During the new cost-containment era, the government considered the extensive rights of the Self Government on budgetary decisions as a potential threat to the proposed budget cuts and so it curtailed these rights in 1996 [176; 177]. In addition, the government weakened the bodies by restructuring them in 1997 [178]. The number of representatives was decreased and members were no longer elected, but delegated, which was later found to be unconstitutional [368]. This decision, however, had lost its significance given that shortly after, the next (Orbán) government abolished the autonomy of the social insurance funds altogether [133].

The government was not satisfied with the new payment methods either, and after a long debate, introduced a fixed element into the payment system [369; 370,10(3)/20(8)]. Hospitals received 20% of their budget in advance regardless of their actual performance, which was seen as the first step in the restoration of line item budgeting [41]. On the other hand the long transition of the DRG payment scheme to achieve a nationally uniform base rate (instead of the institution specific base rates of the transition period) was ordered to be speeded up in 1996, and by March 1998 the rate was not just uniform, but it was fixed in advance [370,15(3),24(6)].

The last significant legislative package of the Horn era came in the form of new laws for social insurance [119], statutory health insurance [2] and health [1]. Apart from some new institutions, like the National Health Council, or the hospital supervisory councils, these acts did not establish new reform principles or any significant change in the structure of the health care system. The significance of *Act CLIV on Health* was the declaration of patient rights, which had not previously been regulated comprehensively [1,6-25]. The Act also established patients' right representatives and arbitration for resolving disputes between patients and health care providers [1,28-34].

The Horn government implemented a strict cost-containment policy, which resulted in a significant cut in the health care budget. By the end of 1997 health care expenditures were almost 30% lower in real terms than in 1990 while, in the same year the GDP increased by 4.6% (see Table A1.4. in Appendix A1 and Table 1.2. in Chapter 1). Having been preoccupied by economic stabilization, little time remained for thinking about the future of the health care system. Nevertheless, within the framework of a World Bank loan, the Ministry of Welfare launched a regional modernization project and, in 1998, the Ministry of Finance prepared a proposal, which envisaged financing reform by introducing competition between insurance funds [179]. This was intended as a joint proposal with the Ministry of Welfare, but the leadership of the ministry were against insurance competition. Even if a consensus had been reached, the government had no time left to put the idea into practice, since the 1998 elections brought the opposition parties into power [167]. Interestingly, the strongest opposition party had taken up the idea of competition, and the debate continued during the first year of the new government.

A.2.4.4. Searching for the way forward in the context of continued cost containment: the period of the Orbán government (1998-2002)

The government of Prime Minister Orbán essentially continued the cost-containment policy of the Horn government, while political battles took place in the background

around competing policy proposals about the desirable direction of further health care reform. The government ceased the World Bank supported regional modernization project, instead launching a pilot project based on the fundholding model and managed care experiments (the so-called 'care-managing pilot'). However, overall, the Orbán government failed to produce tangible improvements in health sector performance.

One of the first measures of the new government was to abolish the autonomy of the social insurance funds, thereby taking full control over the HIF, and the NHIFA [133]. The control of the NHIFA was transferred to the Prime Minister's Office [134], which was strengthened, following a chancellery model [371].

The changes resulted in an interesting political set up, in which three different actors embarked on health policy making. The first, the Secretariat for the Supervision of the Social Insurance Funds of the Prime Minister's Office, proposed a model of competing health insurance funds. The second, the Department of Strategic Analysis of the Prime Minister's Office rejected the idea of insurance competition, as did the third one, the MOH, with the latter two proposing development of the purchasing function. The battle went on for more than a year, when finally the Prime Minister dropped the plan for insurance competition and shifted the supervision and control of the NHIFA to the Ministry of Finance [135]. The MOH regained its primacy in health policy making, and instead of financing reform, the policy focus was shifted to the delivery system, but within a context characterized by persistent efforts of the government to contain overall health expenditure.

Throughout the whole period, the government targeted both the revenue and the expenditure side of the HIF. The key element of the latter was the pharmaceutical sub-budget of the HIF, which seemed uncontrollable. In order to overcome the problem of contribution evasion, the government extended and increased the hypothecated health care tax [123], and decreased substantially the health insurance contribution from 18 to 14% [180]. The expenditure side was more problematic, since there was no way to cap the pharmaceutical budget as had been done with other budget lines of the HIF. Nevertheless, the government kept a close eye on the pharmaceutical budget by requiring overspending to be approved in advance, and allowing the Minister of Health to vire between sub-budgets of the HIF or from the budget of the MOH [126,4(1)d,5(3)]. With the same law, the government shifted responsibility for collection of contributions to the Tax Office, abolished the partial fixed element in the payment system and initiated the 'care managing pilot' [126,24-31,19,16].

The essence of the so-called 'care managing pilot' is that health care providers have the opportunity to take responsibility for the whole spectrum of care of a population of up to 200,000 inhabitants [126,16; 120,50]. The NHIFA sets up a so-called 'virtual budget', which is the number of persons in the managed care pilot multiplied by an adjusted capitation fee. During the year the actual costs incurred by the patients of the managed care pilot concerned are summarized, and if actual costs are smaller than the 'virtual budget', the difference is paid to the 'care-organizer' health care institution. Savings can be used for remuneration purposes. The great advantage of this pilot programme is that it does not change how the system operates, and if anything goes wrong, the care-organizing responsibility can be withdrawn without any risk of people remaining without adequate care. The first pilots were launched in 1999, and currently there are five 'care-organizing' institutions (hospitals, polyclinics and groups of family doctors), the largest of which is the *Misszió* not for profit corporation at Veresegyház.

After the rejection of health insurance competition and the launching of the 'care managing' pilot, the first delivery side reform measure of the MOH came in the beginning of 2000, when the 'practice right' was introduced with the original objective to create a market for family doctor practices [185; 186]. The government offered subsidized loans for family doctors to help them buy their surgery and equipment from local government [186]. During the second half of 2000, however, nothing significant happened, as far as reform of the delivery system was concerned, but the government continued its battle against rising pharmaceutical expenditures. The Social Insurance Price and Subsidy Committee was established [342], and negotiated a long term agreement with the representatives of the pharmaceutical industry to secure a price increase below inflation level over a three year period [372]. Further measures included the revision of the subsidy system, and the decrease of wholesale and retail price margins of expensive medicines, both of which were implemented in 2001 [182-184]. As a revenue side measure, the upper ceiling of the employee health insurance contribution was abolished [181].

In the beginning of 2001 a new minister of health was appointed, who managed to retrieve the supervision of the HIF from the Ministry of Finance [121]. The *1996 Capacity Act* was repealed [310], and a 10-year public health action programme was elaborated with the goal of increasing life expectancy of men and women, to 70 and 78 years, respectively [373]. The implementation of the programme has begun, coordinated by a project unit in the NPHMOS and it seems that it will continue during the current government. The reform of the delivery system continued with establishment of the 'freelance' physician status, and encouragement of the corporatization of public providers [130]. These measures, however, were only a late attempt to demonstrate that the government had a clear vision about health care reform. It was not realistic to expect any tangible results by the end of the electoral cycle, and the 2002 general elections brought the Hungarian Socialist Party and the Alliance of Free Democrats back to power [167]. Indeed, the whole period was characterized by an uncertainty about the desired direction of future health care reform. The only exception was cost containment, which was implemented with great determination, despite fast and stable economic growth (see Table A1.4. in Appendix A.1). On the other hand uncertainty implied cautious and hence not irreversible changes, which left open most of the 'pathways' for health care reform.

A.2.4.5. The plans and first measures of the Medgyessy government (2002-)

The new coalition is in a difficult position regarding health care reform. First, they have a small majority in the National Assembly, a new situation in the post-communist history of the country, and any disagreement between the coalition parties could threaten the stability of government [167; 23,31.6]. Second, the coalition parties have opposing views on the future direction of health care reform. The Alliance of Free Democrats is convinced that insurance competition is the way forward, while the stronger coalition partner does not agree with this [374; 375]. Third, the health care system is generally viewed to be in a bad shape, and decisions on what to do cannot long be delayed without risking a crisis [376-379]. Fourth, although economic growth is still dynamic, especially compared to the unfavourable situation in the world economy, it slowed in 2002, and the delivery of election promises created a deficit in the state budget [380; 312]. Fifth, the country is on the threshold of EU accession and

expects to join in 2004. It is dubious whether one and a half years will be enough to alleviate the tensions within the health sector to the point that the challenges of the internal market will not pose a great threat to the viability of the system.

The government programme has reflected the ambiguous situation within the coalition. Although the Hungarian Socialist Party was awarded the MOH, plans for health sector reform are a mixture of everything from regionalization to a more liberal privatization policy, from medical savings accounts, through strategic purchasing to the extension of the 'care managing pilot'. Even the possibility of insurance competition has been left open [322]. A key element in the government programme is the consolidation of the health sector, but it is not clear what the system will look like. It may, however, be beneficial if this lack of a clear direction implies a willingness to draw on careful assessment of evidence.

A promising first step by the new government was to introduce a long awaited substantial pay rise for the health care workforce [312]. Averaging 50%, this seems to be sufficient to at least stop the exodus of health workers, but may not be enough if EU accession makes it easier to take a job in wealthier Western European countries. On the other hand the first signs of a worsening economic climate question whether it will be possible to sustain these improved conditions.

The autumn of 2002 has seen structural reform enter into policy formulation. The prime minister has appointed a governmental commissioner, who has set up 12 committees that are to prepare proposals concerning various areas of health care reform. The government has already suspended some of the restrictions on the privatization of delivery organizations and more liberal regulations are expected to replace the existing one [312; 381], but the new vision on the health care system is not yet known.

The effect of the new legislation at the end of 2001 and the first measures of the new government, especially the 50% pay rise, on informal payment has yet to be seen, but as indicated by the response of the former minister of health to a parliamentary question, expectations are high that these measures will ultimately eliminate informal payment from the system. Nevertheless, it is conspicuous from the above summary of health care reform in Hungary that there have been no attempts to tackle the problem directly [50; 67].

A.2.5. CONCLUSIONS

Hungarian health care reforms in the 1990s have sought answers to the crisis of the state-socialist health care system, in the context of massive political, social and economic changes. Health policy-makers envisaged a smaller, but more efficient health sector, which would provide high quality services for everybody at an affordable cost. Early structural reforms have established the new contract model of health services and introduced incentives for efficiency via output based provider payment methods. Nevertheless, further reform efforts were overwhelmed by strict cost-containment policies, which were characterized by centralization and direct government interventions.

The most important challenges the Hungarian health care system faces are the disappointing health status of the Hungarian people, and the continuous financial pressure, despite the fast and stable economic growth of the past 5 years. After 15 years

of continuous reform, the health sector is still struggling with the legacy of the state-socialist system, which informal payment has remained integral part of.

APPENDIX B.

B. ANNEXES FOR QUALITATIVE INTERVIEWING

B.1. Characteristics of the sample

Tables B1 and B2 describe the basic demographic and socioeconomic characteristics of the 15 patients interviewed personally in Kecskemét, and Table B3 the composition of the physician sample, which includes all the 31 medical doctors interviewed either in Kecskemét, the private hospital, or Budapest, in order to avoid the identification of the interview subjects.

Table B1. Characteristics of the patient sample in Kecskemét

Table with 7 columns: #, Sex, Age, Family status, Education, Occupation, Remarks. It contains 21 rows of patient data, including details like age, sex, marital status, education level, and occupation.

Notes: n.a.=not available

Table B2. Characteristics of the patient sample in Kecskemét (summary)

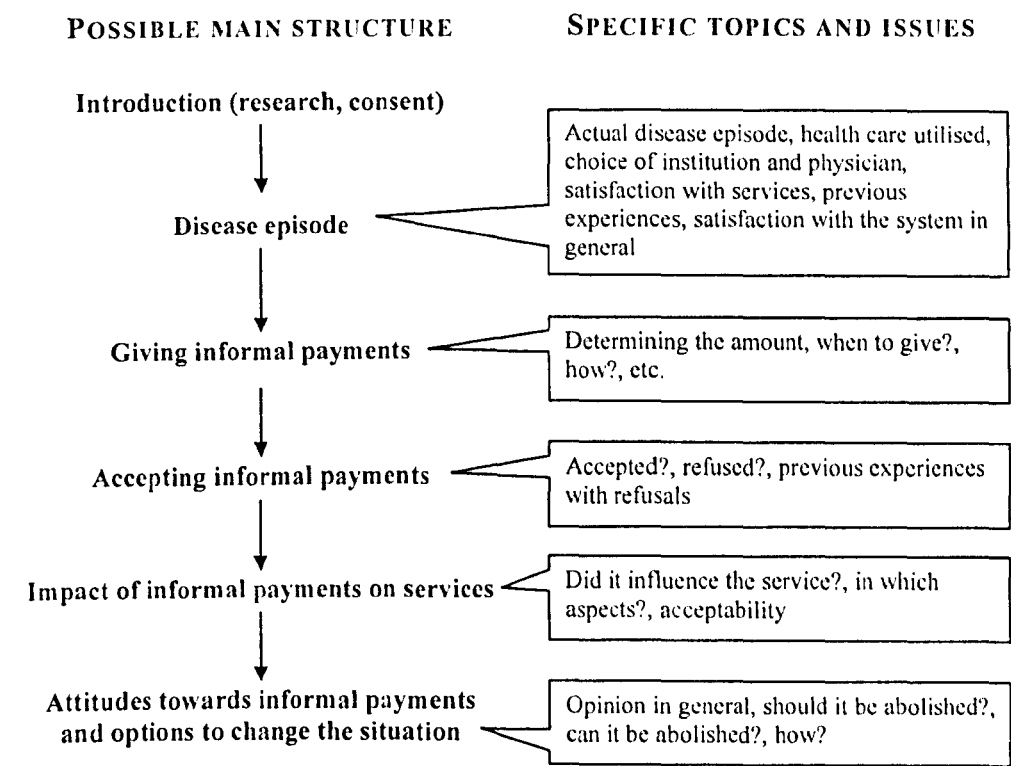
Summary table with 11 columns: Sex (F, M), Age (20-44, 45-59, 60+), Education (primary, secondary, higher), and Occupation (active, inactive, unemployed). It provides counts for each category.

Notes: M=male, F=female

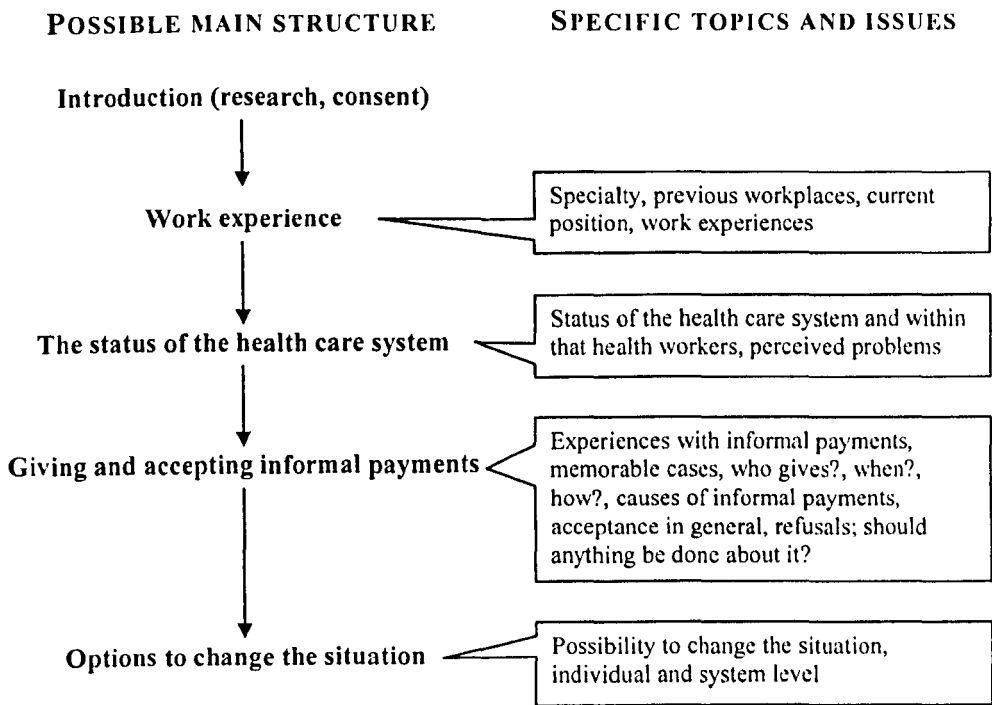
Table B3. Characteristics of the physician sample

Attribute		Number of Physicians	Total
Gender	female	12	31
	male	19	
Age	25 – 35 years	8	31
	36 – 45 years	13	
	46 – 60 years	9	
	over 60 years	1	
Specialty / level of care	primary care	3	27
	internal medicine	8	
	surgery, traumatology	5	
	obstetrics-gynaecology	3	
	anaesthesiology	2	
	psychiatry, neurology	2	
	paediatrics	2	
	'small' clinical specialty (ophthalmology, urology, orthopaedics, rheumatology, etc.)	2	
	diagnostic (laboratory medicine, radiology, etc.)	4	31

B.2. Interview format for patients



B.3. Interview format for physicians



APPENDIX C.

C. ANNEXES FOR THE PRIVATE SECTOR INFORMAL PAYMENT CASE STUDY

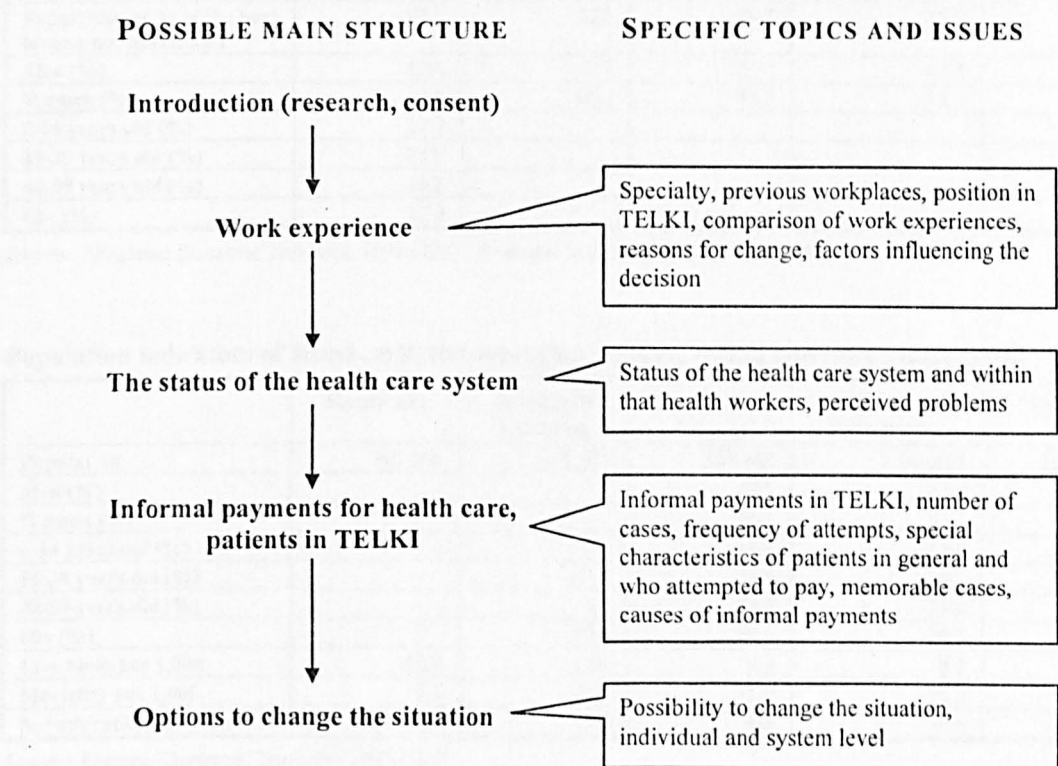
C.1. Characteristics of the patient sample

Table C1 describes the basic demographic and socioeconomic characteristics of the 6 patients interviewed in the frame of the case studies (3 patients of the private hospital and 3 in Kecskemét).

Table C1. Characteristics of the patient sample (case studies)

#	Sex	Age				Family status	Remarks
		<25	25-49	50-64	65+		
1	♀		x			married	(1ph3128c)
2	♀			x		married	together with her husband (1ph4114c)
3	♀		x			married	together with her husband (1ph2365c)
4	♀	x				married	(1ph7132c37)
5	♀			x		married	(2ph27c315)
6	♀			x		married	mother about son's case (2ph689p47)

C.2. Interview format for physicians



APPENDIX D.

D. ANNEXES FOR THE HOUSEHOLD SURVEY

D.1. Study population

The population of larger towns, which are designated as the centres of counties in Hungary, ranged between 35 and 200 thousand in 2001 except for the capital, Budapest which had a population of almost 2 millions [23]. For the purpose of the study, the town of Kecskemét, the seat of Bács-Kiskun county was selected. The county is located in the Southern central part of the country, between the rivers Duna (Danube) and Tisza. As part of the larger geographic region of the Great Plain, the county is low lying. It is the most Western county of the statistical-planning region of the Southern Great Plain.

The county town of Kecskemét is located near to the northern border of Bács-Kiskun county, being halfway between Budapest, the capital, and Szeged, the seat of Csongrád county. With a population of 105,000, Kecskemét is the 8th largest among the 19 county towns [23]. The public administrative borders of the town delimit 3.5‰ of the territory of the country. It has a densely populated urban core, and a surrounding area of small farms and 8 villages: Katonatelep, Borbás, Kiszfai, Matkó, Kadafalva, Hetényegyháza, Talfája, Méntelek. The Ministry of Defense has a military airport, a military camp and a hospital (the so-called ‘air-hospital’) at Kecskemét.

Table D1. Area and population of Kecskemét, the subregion, county, region and the country, 2001

	Kecskemét	Kecskemét Subregion	Bács-Kiskun County	Southern Great Plain Region	Country
Area (km²)*	321	1,458	8,420	18,314	93,030
Population	105,138	167,482	546,753	1,377,219	10,195,513
Population as % of the next largest territorial unit	62.8	30.6	39.7	13.5	-
Men (%)	47.0	47.7	47.7	47.7	47.7
Women (%)	53.0	52.3	52.3	52.3	52.3
0-14 years old (%)	17.3				16.8
15-39 years old (%)	36.0				35.0
40-59 years old (%)	26.8				28.0
60+ (%)	19.9				20.2

Source: *Regional Statistical Yearbook, 1999 [382] ; Preliminary Data of Census, 2001 [284]

Table D2. Population indicators of Kecskemét, the subregion, county, region and the country, 1999

	Kecskemét	Kecskemét Subregion	Bács-Kiskun County	Southern Great Plain Region	Country
Population	105,606	162,853	532,465	1,341,835	10,043,224
Men (%)			47.7	47.9	47.7
Women (%)			52.3	52.1	52.3
0-14 years old (%)			17.6	17.1	17.1
15-39 years old (%)			34.8	34.3	35.3
40-59 years old (%)			27.5	27.9	27.9
60+ (%)		17.9	20.1	20.7	19.7
Live birth per 1,000	10.0	10.0	9.4	9.1	9.4
Mortality per 1,000	11.3	12.3	15.0	15.2	14.2
Net migration per 1,000	2.7	2.2	0.4	-0.5	-

Source: Regional Statistical Yearbook, 1999 [382]

Table D3. Households of Kecskemét, Bács-Kiskun county and the country as a whole, 2001

	Kecskemét		Bács-Kiskun county		Country	
Number of households	40,149		208,163		3,837,048	
Size of households	100%		100%		100%	
Average size	2.51			2.57		2.60
1 person (%)		26.1		26.1		25.6
2 persons (%)		30.8		28.7		28.5
3 persons (%)		18.9		19.4		20.0
4 persons (%)		17.2				16.9
5 persons (%)		4.8		23.2		6.1
6+ persons (%)		2.0		2.6		3.0
Family structure	100%		100%		100%	
One-family (%)		68.5		68.8		68.4
couple		57.5		58.5		57.8
single parent		11.0		10.3		10.6
Two-family (%)		2.2		2.4		3.1
Three+ family (%)		0.1		0.1		0.2
One-person (%)		26.1		26.1		25.6
Other type (%)		3.1		2.6		2.8
Economic activity	100%		100%		100%	
1 employed person (%)		33.6				30.7
2 employed person (%)		24.7				22.9
3+ employed person (%)		5.5				5.8
No employed person		36.2				40.7
unemployed		2.8				4.2
inactive		32.7				35.4
dependant only		0.5				0.9

Source: Preliminary Data of Census 2001

Table D4. Economic indicators of Kecskemét, the subregion, county, region and the country, 1999

	Kecskemét	Kecskemét subregion	Bács-Kiskun county	Southern Great Plain region	Country
GDP per capita ('000 HUF)			717	768	1,005
Gross taxable income per person (HUF)		288,619	228,577	243,249	308,575
Income tax per person (HUF)		62,106	44,272	47,780	69,421
Unemployment (%)		5.6	10.1	10.5	9.6
Number of businesses per 1,000 population	100	86	70	70	80
Persons exempt from health care co-payments per 1,000		42	52	51	47

Source: Regional Statistical Yearbook, 1999 [382]

Table D5. Selected health care indicators of Kecskemét, the subregion, county, region and country, 1999

	Kecskemét	Kecskemét subregion	Bács-Kiskun county	Southern Great Plain region	Country
Population per family doctor and family paediatrician	1,447	1,480	1,493	1,497	1,490
Outpatient specialist contacts per 1,000 population	16.0		12.2	16.5	14.6
Hospital beds		1,561	3,770	10,185	83,992
Bed occupancy (%)		77.8	75.4	77.6	77.0
ALOS (days)		8.3	8.3	8.6	9.2

Source: Regional Statistical Yearbook, 1999 [382]

The town is the natural centre of surrounding settlements, with an inner circle of four villages, and an outer circle of two small towns and eleven villages. This group of settlements, the agglomeration of Kecskemét is one of the 10 small regions of the Bács-Kiskun county, serving statistical and planning purposes, referred to as the Kecskemét

subregion. Tables D1, D2, D3, D4 and D5 presents some selected demographic, social, economic and health care indicators in comparison with the country as a whole.

D.1.1. HEALTH CARE SUPPLY IN KECSKEMÉT

The provision of health services is shared between the municipality and the county government according to the original division of tasks set by the *Local Government Act* [43]. That is, the municipality provides only primary care, while the county government provides all secondary and tertiary care services.

Kecskemét had 65 primary care districts/units, 43 of which were family physician and 22 were family paediatrician practices, in 2001 [383]. Thirty-three family physicians and 19 family paediatricians worked as private entrepreneurs in 2001, i.e. 80% of all family doctors. In addition there were 6 family doctors, 2 physicians and 4 paediatricians, who worked without local government contract, i.e. without territorial supply obligation, and 5 of the family doctors ran totally private surgery, but only on a part time basis. There were 28 publicly employed dentists, who provided dental primary care in the frame of statutory health insurance in 2001, 12 of them had a part time private surgery. Altogether 97 private dentists were working in Kecskemét in 2001, including the aforementioned 12.

Public primary care included 38 mother and child health nurse service (MCH) units with publicly employed MCH nurses, who provided pre- and perinatal care in 35, and youth care in 3 units. School health services were provided by 3 medical doctors, all of them being private entrepreneurs in 2001.

The county government owns the 1196-bed county hospital, which provides secondary and tertiary care services for the population of the entire county in general surgery, traumatology, orthopaedics, neurotraumatology, internal medicine, neurology, ob-gyn, psychiatry, rheumatology and rehabilitation, paediatrics with perinatal intensive care, urology, ophthalmology, ENT, intensive care, pathology, computerised tomography, MRI, dialysis and oncology. Dialysis services are provided by a private company that has a contract with NHIFA. In 2001 two-hundred and forty-eight beds were for chronic care, the rest were for acute care. All public outpatient specialist services are provided at the county hospitals, i.e. the municipality does not have independent polyclinics or dispensaries. Inpatient and outpatient specialist services are also provided at another 181-bed hospital, the so-called 'air-hospital', which is owned by the Ministry of Defence. Beds are shared between internal medicine, general surgery, traumatology, neurology, ophthalmology, rheumatology and intensive care. All of these beds were for acute care in 2001. In addition there is a special department in the hospital dedicated to aviation medicine.

There are four other municipal hospitals in the county, within a short driving distance from Kecskemét at Kiskunfélegyháza, Kiskunhalas, Kalocsa, Baja. Moreover, Budapest and Szeged, with university medical faculties, are also under an hour's drive from Kecskemét.

Private health care providers are limited to part time surgeries, except for dental care and family doctor's services, the latter in the frame of 'functional privatization'. Altogether there were 232 registered private providers in Kecskemét in 2001, excluding private primary care surgeries and dental care providers [383].

D.1.2. GENERAL COMPARISON OF KECSKEMÉT AND THE COUNTRY

The population of Kecskemét and the whole country are compared using the preliminary data of the 2001 Census [284].⁶² Tables D6.1-D6.5 represents differences between the age, sex, marital status, education, economic activity and occupation composition of the population (or relevant population subgroups) of Kecskemét, and the country. The difference between the share of a particular population subgroup in Kecskemét and in the country is expressed with the former as percentage of the latter. That is, 100% means no difference, a figure over 100% means that the share of the population subgroup is larger in Kecskemét than in the country and vice versa. Since the preliminary census data are based only on a sample of counting districts, the sampling error has to be taken into account when data are interpreted. Unfortunately, information on sampling error for the data on the population and households of Kecskemét has not been published, so the following comparison presents only a rough impression of possible differences. Their statistical significance cannot be determined from the available data.

The data show that Kecskemét has a slightly younger population than the country. This difference is more marked in the female population. Among those aged 15 and over, there are more single women, and fewer couples, and there is a substantial excess in the share of divorced persons in Kecskemét.

Table D6.1. Population sex, age difference, 2001 (Kecskemét/country)

Sex	Total	Age 0-14 years (child)	Age 15-39 years (young adult)	Age 40-59 years (old adult)	Age 60+ years (elderly)	Children and elderly	Children	Elderly	Elderly per 100 children
						per 100 adults			
Male	98.4%	101.9%	101.7%	94.3%	103.8%	104.4%	101.9%	105.3%	101.8%
Female	101.4%	103.2%	104.4%	97.5%	94.7%	96.9%	102.0%	93.5%	91.7%
Total		102.5%	102.9%	96.0%	98.4%	100.4%	102.6%	98.6%	96.0%

Source: Population Census, 2001 [284]

Table D6.2. Population marital status difference (among 15+), 2001 (Kecskemét/country)

Gender Age group (years)	Total	Single	Couple	Widow	Divorced
Male	98.5%	102.1%	97.4%	86.9%	116.7%
Female	101.3%	114.2%	94.3%	85.6%	124.4%
Total		107.1%	95.7%	86.6%	121.5%
Female aged					
15-49	103.3%	109.7%	88.2%	82.2%	131.8%
50+	95.7%	131.4%	103.2%	89.5%	114.1%

The population of Kecskemét is better educated than that of the country as a whole, which is especially discernible in higher education, where the excess is almost 50%. It is also more active economically, with less unemployment. Among the employed population, white-collar managerial occupations are over-represented compared to the

⁶² The statistics have been computed on the basis of a representative sample of counting districts, so they are not the final results. The estimation of sampling error for the national data can be downloaded from the web-site of the Census (<http://www.nepszamlalas2001.hu>).

country, which is line with educational differences. Among blue-collar occupations, there is excess employed in services, coupled with an under-representation of agriculture, industry.

In summary, there are certain differences between the population of Kecskemét and the population of country. The most marked differences (over 35%) are the share of people with higher education, the share of unemployed and the share of blue-collar workers in agriculture (shaded grey in Tables D6.1-D.6.5).

Table D6.3. Population education difference, 2001 (Kecskemét/country)

Age Group (years)	Year (Class)						Completed	
	Elementary (<6)	Elementary (6-7)	Elementary (8)	Secondary (9-11)	Secondary (12-15)	Higher education (1-7)	at least 8 elementary	at least 12 secondary
7+	103.9%	81.5%	93.2%	83.9%	106.6%	143.0%	101.6%	119.4%
15+	94.6%	73.6%	94.3%	84.4%	107.3%	143.9%	102.5%	120.2%
18+	94.9%	73.3%	89.7%	86.0%	107.9%	144.7%	102.5%	120.9%
25+	94.5%	73.8%	89.5%	87.7%	107.1%	147.7%	102.9%	121.6%

Table D6.4. Population economic activity differences, 2001 (Kecskemét/country)

Age Group (years)	Total	Active			Inactive		
		Together	Employed	Unemployed	Together	Inactive Earner	Dependant
15-29	101.8%	96.3%	101.4%	66.7%	103.9%	84.8%	110.2%
30-39	106.3%	105.9%	111.0%	59.9%	78.7%	79.0%	77.4%
40-59	96.5%	109.2%	111.2%	86.1%	82.4%	81.1%	96.3%
60-74	102.0%	140.2%	147.1%	3.5%	98.4%	98.9%	57.4%
75+	91.6%	120.8%	124.3%	47.5%	99.8%	98.6%	187.7%
Total		105.6%	109.5%	71.6%	94.7%	90.6%	108.8%

Table D6.5. Population occupation differences, 2001 (Kecskemét/country)

Sex	Total	Occupation					
		Manager, white collar	Other white collar	Service	Agriculture	Industry, Construction	Other
Male	98.2%	117.9%	78.5%	107.7%	68.9%	86.1%	155.7%
Female	102.2%	113.9%	96.9%	113.3%	33.8%	82.2%	94.0%
Total		116.1%	93.5%	111.2%	59.1%	84.4%	126.1%

D.1.3. COMPARISON OF HOUSEHOLDS OF KECSKEMÉT AND THE COUNTRY

In Table D7, the same method of comparison is applied to households. Two and three+ family households are underrepresented in Kecskemét, but these together make up less than 4% of all households (see Table D3). In the case of other household types, the difference is within 10%. Larger households are under, while 2-person households are over-represented compared to the country.

In line with the lower rate of unemployment, families and households with unemployed person are under-represented, as are households with only dependants although the latter are less than 1% of all households in the country (see Table D3).

Furthermore, households in Kecskemét live in dwellings more likely to have modern conveniences [284].

Table D7. Differences between the households of Kecskemét and of the whole country, 2001

	Household	Persons per 100 households	Family
Structure of households			
One-family	100.2%	97.8%	
Couple	99.5%	97.8%	
Single parent with child	103.8%	98.2%	
Two-family	72.0%	96.2%	
3+ families	55.2%	114.3%	
Family household total	98.8%	96.7%	
One-person	102.2%	100.0%	
Other	109.5%	97.4%	
Non-family household total	102.9%	100.3%	
Total		96.6%	
Age composition			
Only young (40-)	101.5%	94.2%	
Only middle aged (40-59)	107.1%	96.5%	
Only elderly (60+)	102.8%	103.1%	
Young and middle aged	102.7%	97.5%	
Young and elderly	69.7%	88.8%	
Middle aged and elderly	83.5%	96.7%	
All age groups	81.6%	96.0%	
Total		96.6%	
Size of households			
1 person	102.2%		-
2 persons	108.1%		103.1%
3 persons	94.7%		94.9%
4 persons	101.8%		104.1%
5 persons	80.0%		91.9%
6+ persons	69.2%		72.5%
Economic activity			
1 employed person	109.6%		101.2%
2 employed persons	107.8%		109.2%
3+ employed person	94.9%		106.0%
No employed person			
unemployed	67.0%		55.4%
inactive earner	92.5%		93.9%
only dependant	57.9%		115.4%

Source: Population Census, 2001 [284]

In summary, the households of Kecskemét have a similar structure and composition to the country as a whole, but households with two or more families, and larger households with 5 persons or more are under-represented, while 2-person households are over-represented in Kecskemét, which leads to a slightly smaller average household size compared to the country. Poorer households with unemployed and dependants only are also under-represented.

Unfortunately, other important household attributes, such as health status, household income, expenditures and the ownership of consumer durables are not available in the published official statistics for Kecskemét. The report of the annual household budget

survey of the Hungarian Central Statistical Office is broken down only to the regional level. As can be seen from the available data in Tables D2 and D4, the Southern Great Plain region is not a good proxy for the town of Kecskemét. Thus the assessment of comparability of the households Kecskemét and of the country is only partial.

The comparability of health care utilization data merits separate discussion. Although health care utilization data are available for Kecskemét as far as specialist inpatient and outpatient care are concerned, these cannot be compared meaningfully with national data (see Table D5). Health care providers in Kecskemét serve a far larger population than the inhabitants of the town. Moreover, Kecskemét is located halfway between Budapest and Szeged, both of which have even more extensive health care supply, including universities with medical faculties. Unfortunately there are no official statistics available from which health care utilization data could be assessed according to place of residence.

D.2. Sampling frame and method

A household sample was requested from the Central Population Registration and Electoral Office. The Office manages a database of residents in Hungary, each of whom has a personal identification number. The personal data set includes the personal identification number, name, maiden name, mother's and father's name, date of birth and address. The Office will create random population and household samples for research purposes, after assessing the conformity of the research with the requirements of the Data Protection Act, as well as the institution that is responsible for the project.

The household sample was created in two steps. First, all residential addresses are included in a database (the household database). Second a random sample is made from this household database, according to the required sample size. This two-step process ensures that each residential address has an equal chance to be in the sample. The sampling method provides a representative sample of the households in a given area, except for those households living at the same residential address. These households have a smaller chance to get into the sample, since in these cases two (or more) households are represented with only one address in the sampling frame. The magnitude of this sampling bias can be assessed using the housing data of the 2001 Census as the difference between the number of households and the number of inhabited dwellings [284]. Table D8 shows these data for Kecskemét and the country.

Table D8. Assessment of the proportion of households living in the same accommodation

	Kecskemét	Country	Kecskemét/country (%)
Number of households	43,409	4,309,627	
Difference between households and inhabited dwellings	4,322	631,543	
Percentage of non-sharing households	80.1%+	70.7%+	113.3%
Percentage of households share accommodation	<19.9%	<29.3%	

The percentage of households who live under the same roof cannot be determined exactly from the available data, since it is possible that more than two households share the same accommodation. Hence, the percentage of non-sharing households in Table D8 is the minimum possible, assuming that there are only two-household sharers.

Nevertheless, there was no other sampling frame available that would have eliminated this bias.

After the Central Population Registration and Electoral Office provided the sample addresses, the corresponding telephone numbers were identified, using the available electronic telephone directories (CD, internet), and the public directory enquiry service. In certain cases, it became necessary to identify the names first, because of the inaccuracies of the available directories.

The obvious advantage of the sampling method was that it included those households who did not have a telephone, and offered the possibility of using face-to-face interviews in households with no (public) telephone line. In the data collection phase of the research, face-to-face interviews proved to be very time-consuming and had to be dropped due to budget constraints.⁶³

Alternative sampling frames were considered but were discarded early on because of other possible sampling biases. Public telephone directories as sampling frames have the disadvantage that they do not necessarily list each domestic telephone number only once. For instance, it can happen that both partners in a couple appear in the directory with the same number. This suggests that without the possibility of filtering the public telephone directory, single person households have less chance to get into the sample, introducing a sampling bias.⁶⁴ In principle this bias could be avoided by using the number ranges of domestic telephone lines, having the additional advantage of including secret telephone numbers, which otherwise would be unreachable. Unfortunately, the Hungarian telephone company, MATÁV considers this information a commercial secret, so it is not available for research (personal communication).

D.3. Sample size and characteristics of the sample

The Central Population Registration and Electoral Office provided 1,500 residential addresses in Kecskemét. As the first step, the telephone numbers (and addresses without telephone) were determined, which yielded 1,092 numbers. From these 930 numbers were answered, and 113 persons declined to participate in the survey, a 87.8% response rate. Interviewers were asked to record the gender of the persons who refused to answer, and to enquire about the cause of rejection. Table D9.0 provides a breakdown of the causes. In most cases the respondents did not give any further explanation, but there were cases where refusal was directly related to the topic: (a) the person worked in the health sector, (b) the person utilized health care and had bad experiences.

Nine questionnaires are incomplete, because the respondent refused to answer in the middle of the interview. These were included in the analysis. The rest of the questionnaires are complete, except for certain sensitive questions, such as the income of the household.

⁶³ The work of three interviewers over a two-day period yielded only 10 interviews.

⁶⁴ It has to be noted, that this phenomenon might reduce the sampling bias concerning households, which share accommodation, insofar as double listing represents these households. However this is just a theoretical remark, since there is no possibility to link sharing households to telephone numbers.

Table D9.0 Reasons for non-responses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no reason	39	34.5	34.5	34.5
	health problem, bad opinion	10	8.8	8.8	43.4
	mistrust	19	16.8	16.8	60.2
	does not use services	4	3.5	3.5	63.7
	not enough time	24	21.2	21.2	85.0
	health worker	5	4.4	4.4	89.4
	other	12	10.6	10.6	100.0
Total		113	100.0	100.0	

The characteristics of the sample are assessed on the basis of household attributes, which are available for the study population, the households of Kecskemét and the country as a whole. The results are shown in Table D9.1-D9.4.

Table D9.1. Structure of households in the sample, and differences between the household sample and households of Kecskemét and the country

Structure of households		Freq	%	Valid %	2 SE	Sample / country	SE (for 95% CI)	Sample / Kecskemét	SE (for 95% CI)
Valid	One-family					110.7%	4.4%	110.5%	4.4%
	Couple	554	67.8	68.1	3.3	117.9%	3.2%	118.5%	3.2%
	Single parent with child	62	7.6	7.6	1.9	71.7%	17.5%	69.1%	16.9%
	Two-family	20	2.4	2.5	1.1	80.6%	35.3%	111.9%	49.0%
	3+ families					0.0%		0.0%	
	Family household total					109.2%	4.0%	110.5%	4.1%
	One-person	118	14.4	14.5	2.5	56.7%	9.7%	55.5%	9.4%
	Other	59	7.2	7.3	1.8	261.6%	65.4%	238.9%	59.7%
	Non-family household total					76.8%	10.2%	74.7%	9.9%
	Total	813	99.5	100					
Missing (System)		4	0.5						
Total		817	100						

Source: Comparison is based on Population Census, 2001 data [284]

Table D9.2. Economic activity of households in the sample, and differences between the household sample and households of Kecskemét and the country

Economic Activity		Freq	%	Valid %	2 SE	Sample / country	SE (for 95% CI)	Sample / Kecskemét	SE (for 95% CI)
Valid	1 employed person	251	30.7	31	3.25	100.9%	10.6%	92.1%	9.7%
	2 employed person	327	40	40.4	3.45	176.2%	15.0%	163.4%	13.9%
	3+ employed person	94	11.5	11.6	2.25	198.4%	38.5%	209.0%	40.6%
	No employed person								
	with unemployed	19	2.3	2.3	1.05	54.1%	24.8%	80.8%	37.0%
	with inactive person	113	13.8	14	2.44	39.6%	6.9%	42.8%	7.5%
	with dependants only	6	0.7	0.7	0.59	78.1%	65.3%	134.7%	112.8%
	Total	810	99.1	100					
Missing (System)		7	0.9						
Total		817	100						

Source: Comparison is based on Population Census, 2001 data [284]

In general the household sample has considerable differences both in comparison with the study population and the country. There are only few characteristics for which

the difference is not significant (with 95%CI). In most cases, the differences are not larger for the country than for Kecskemét. Moreover there are certain characteristics for which the sample better represents the country than the study population.

Concerning the structure of households, couples are over-, while single-person households are under-represented in the sample. The comparison of other categories may be less meaningful, since there could be differences in the classification criteria applied. There is a deficit of one- and two-person households in the sample coupled with an excess of larger households with 3 persons or over, which results in a significant difference in terms of average household size. Sample households are more active economically and households with inactive earners are underrepresented in the sample. This phenomenon cannot be explained by the better employment indicators of Kecskemét compared to the country, since the difference is similar or slightly larger for the study population, too.

One possible and obvious explanation is that differences between the household sample and the study population are attributable to the possession of domestic telephone line, but this should be confirmed by other studies using telephone interviewing.

Table D9.3. Size of households in the sample, differences between the household sample and households of Kecskemét and the country

Size of Households		Freq	%	Valid %	2 SE	Sample / country	SE (for 95% CI)	Sample / Kecskemét	SE (for 95% CI)
Valid	1 person	117	14.3	14.3	2.45	55.9%	9.6%	54.7%	9.4%
	2 persons	175	21.4	21.4	2.87	75.2%	10.1%	69.5%	9.3%
	3 persons	207	25.3	25.3	3.04	126.6%	15.2%	133.6%	16.1%
	4 persons	225	27.5	27.5	3.12	162.3%	18.4%	159.5%	18.1%
	5 persons	71	8.7	8.7	1.97	143.6%	32.5%	179.4%	40.7%
	6+ persons	22	2.7	2.7	1.13	91.4%	38.4%	132.0%	55.4%
	Total	817	100	100		116.5%	3.5%	120.6%	3.6%

Source: Comparison is based on Population Census, 2001 data [284]

Table D9.4. Differences between average household size (Mean) in the household sample and households of Kecskemét and the country

Average household size	Valid	Missing	Mean ± 2 SE	Sample / country	SE (for 95% CI)	Sample / Kecskemét	SE (for 95% CI)
N	817	0					
Mean	3.03		2.94 - 3.12	116.5%	3.5%	120.6%	3.6%
Std. Error of Mean	0.045						

Source: Comparison is based on Population Census, 2001 data [284]

There were no data available for the income distribution of the households and the possession of certain consumer durables in the study population, so the household sample is compared only to the country for these variables. Table D9.5 shows the income distribution by decile. In order to make the comparison possible, the survey data had to be complemented and recalculated, since 42.5% of the respondents refused to answer the question about their net monthly household income. The response rate was much higher, 88.9%, when the interviewed person was asked to select from predefined ranges, so the information from the two questions was put together by assigning the mean of the range to those households, which refused to tell the exact

amount. In this way an acceptable level of 11.1% non-response rate was achieved, but this imputation has to be taken into account, when the results are interpreted.

As can be seen in Table D9.5, both the average yearly per capita net income overall and by income deciles were significantly different in the household sample from the households of the country (with 95%CI). However, the nature of this difference has changed since the original assessment was made using the 1999 household budget survey data of the HCSO. At that time, the two lowest income deciles corresponded with the country average and from the 3rd to 10th decile, the difference was not just significant, but increasing, which suggested that wealthier households were overrepresented in the sample. However, as new data have emerged for 2000 and 2001, the highest income decile seems to correspond with the country average, while the lowest decile and the average have become significantly different. This suggests that rather the poorer segments of the population are overrepresented in the sample, which is not at all bad for assessment of the equity impact of informal payments.

Table D9.5. Income distribution according to income deciles in the sample compared to the country as a whole (average yearly per capita income in '000 HUF)

SAMPLE 2001		Total	01	02	03	04	05	06	07	08	09	10
N	Valid	726	73	73	73	72	73	72	73	72	73	72
	Missing	91	0	0	0	0	0	0	0	0	0	0
Mean		436	144	221	267	300	339	392	448	501	630	1,126
SE of Mean		12	5	1.5	3	1	2	3	5	3.5	6.5	71
Mean + 2SE		460	154	224	273	301	343	398	458	508	643	1,268
Mean - 2SE		412	134	218	261	299	335	386	438	494	617	984
Median		360	150	225	268	300	336	400	450	492	600	900
Mode		300	150	225	240	300	360	360	450	480	600	900
COUNTRY*												
1999		374	148	218	259	292	322	355	392	441	513	802
2000		425	167									938
2001		506	195									1,099

Source: *Comparison is based on the annual household budget survey data [27; 262; 263]

Table D9.6. Consumer durables per 100 households in the sample compared to the country as a whole

SAMPLE 2001		Car	Weekend house	Colour TV	VCR	Mobile phone	Personal computer	Fridge	Dishwasher
N	Valid	794	797	799	795	795	795	798	735
	Missing	23	20	18	22	22	22	19	82
Mean		0.690	0.062	1.040	0.690	0.720	0.340	1.060	0.080
Standard Error (SE) of Mean		0.021	0.009	0.013	0.018	0.027	0.017	0.011	0.011
Per 100 households		69	6	104	69	72	34	106	8
+ 2SE		73	8	107	73	77	37	108	10
- 2SE		65	4	101	65	67	31	104	6
COUNTRY*									
1999		41	7	104	49	13	11	85	2
2001		44	7	115	51	52	18	84	n.a.

Source: *Comparison is based on the annual household budget survey data [27; 263]

In contrast, as far as the possession of consumer durables is concerned, the sample households seem to be richer (even in the light of new evidence on these items), insofar as the possession of items such as mobile phones, personal computers and cars are good

indicators of the economic situation of households. Nonetheless these two findings does not necessary contradict each other, as we have no information on the distribution of these good nationally. Further, we have to take into account that questions on income are among the most sensitive topics, which suggests that there could be problems in terms of data validity and reliability.

D.3.1. AGE AND SEX COMPOSITION OF RESPONDING PERSONS

Table D10 provides a description of the age and sex composition of those persons who were interviewed on behalf of the households. As it can be seen, women are overrepresented in each age category except for the under 19s. This age category, however, has only very few cases, 1.1% of the whole sample. Consequently women are overrepresented in the sample, which is probably not problematic given that usually women are responsible for managing the budget of the household.

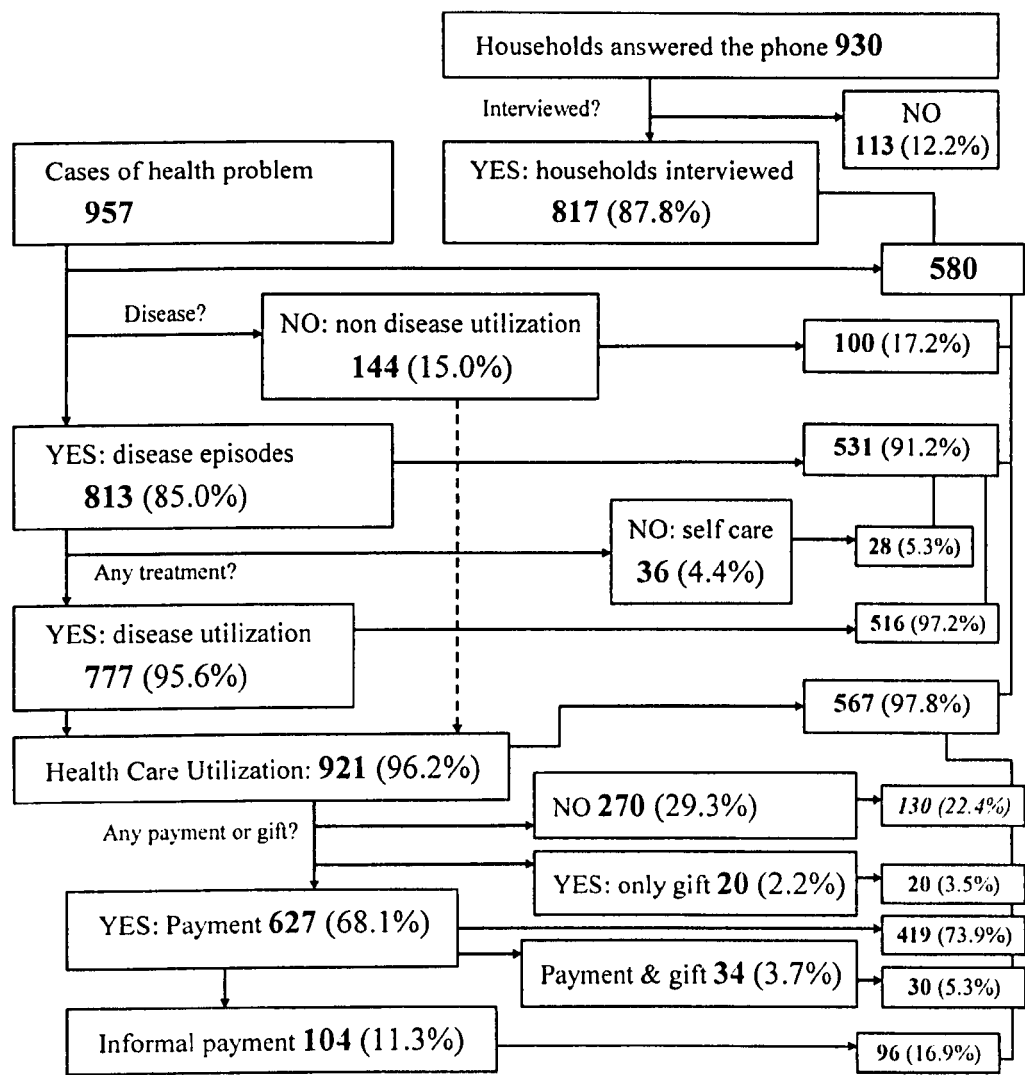
Table D10. Age and gender distribution of responding persons

		The gender of responding persons				Total	
		female		male			
Age category	under 19	4	44.4%	5	55.6%	9	1.1%
		0.7%		2.0%			
	19-45	288	69.1%	129	30.9%	417	51.4%
		51.6%		50.8%			
	46-59	193	72.0%	75	28.0%	268	33.0%
		34.6%		29.5%			
	over 59	73	61.9%	45	38.1%	118	14.5%
		13.1%		17.7%			
Total		558	68.7%	254	31.3%	812	100.0%
		100.0%		100.0%			

D.3.1. OVERVIEW OF HEALTH CARE UTILISATION AND OUT-OF-POCKET PAYMENTS

Another possible source of comparison is related to the topic of the survey. We have national data both on health care utilisation and out-of-pocket payments. Figure D1 provides a general overview of findings concerning health care utilization and out-of-pocket payments, while Figure D2 utilisation according to level of care.

Figure D1. General overview of health care utilization and out-of-pocket payments



Nonetheless, health care utilization of the sample is generally incomparable with national level data, since the questionnaire has yielded aggregate data that, for instance, considers repeated attendance at the same provider as one episode of utilization. The only exception, where this may be less of a problem in terms of comparability, is inpatient care. Table D10.1, which compares hospital utilization per household per 4 months, shows similar figures, but there is still a significantly lower number of inpatient cases in the sample than in the country. However, apart from the readmission problem, comparison is limited by first, the aforementioned time lag between the date of the survey and the latest available year of the country data, and second, health care related refusals mentioned before.

Figure D2. Health care utilization according to levels of care

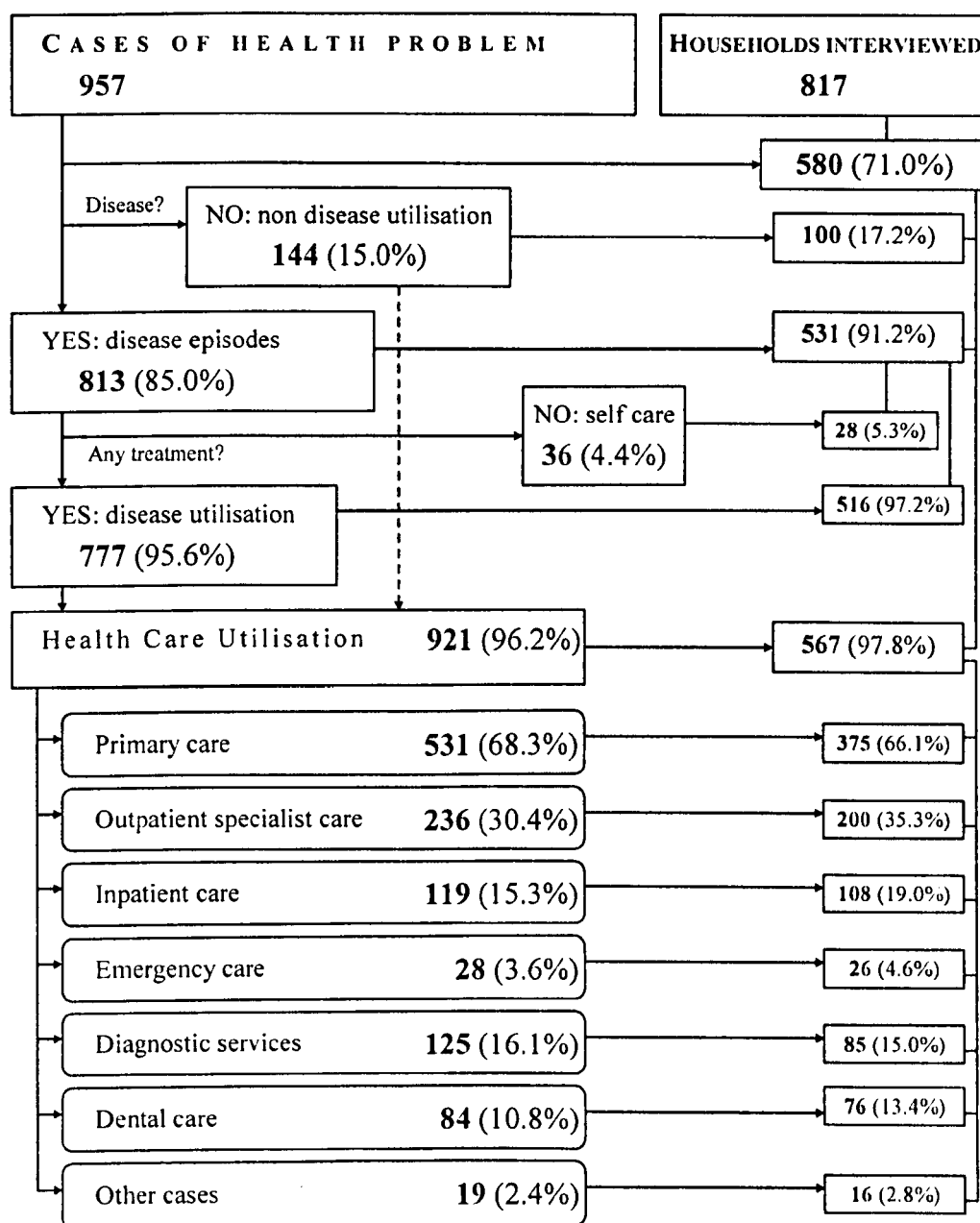


Table D10.1. Comparison of health care utilisation data

CASES	COUNTRY, 1999			SAMPLE, 2001		
	per year	per household	per 4 months	per household	per 4 months	±2SE
Hospital discharges	2,556,000	0.68	0.226	0.44	0.160	0.129-0.191
Emergency cases	2,995,440	0.80		0.10		
Dental care	7,583,000	2.01		0.31		
Outpatient specialist care cases	153,977,948	40.89		1.33		
Primary care	68,845,886	18.28		1.95		
Number of households	3,766,109			817		

Compared to the 2001 household expenditure data of the HCSO, our survey found less out-of-pocket payments in all categories, however, the difference is significant (with 95% CI) only in terms of pharmaceuticals, and consequently the overall amount of out-of-pocket payments. It must be noted, however, that our survey took place in the first half of 2001, thus it measured household health expenditures partly in the last quarter of 2000. Unfortunately, the HCSO do not provide any breakdown of health care expenditures according to the type of service or the type of provider, hence the investigation of the source of the discrepancy is limited to general household variables only. Furthermore, the HCSO has implemented important methodological changes in 2001, which has to be taken into account, when the data are interpreted.

Table D10.2. Comparison of per capita out-of-pocket health care expenditures for 4 months (HUF)

SAMPLE 2001		Pharmaceuticals	Informal payment	Total out-of-pocket payment
N	Valid	817	814	814
	Missing	0	3	3
Mean		1,688	426	3,408
Std. Error of Mean		177	78	323
Mean + 2SE		2,043	581	4,053
Mean - 2SE		1,334	270	2,763
COUNTRY				
2000		2,778	309	4,575
2001		4,504	567	5,692

Source: *Comparison is based on the annual household budget survey data [262; 263]

D.4. The survey questionnaire

The questionnaire had two parts: one which had to be filled in for each responding households (base questionnaire), and one, which had to be filled in for each disease episode, or for each non-disease health care utilisation (insert questionnaire).

Here we provide a translation of both questionnaires and their accompanying instructions.



SEMMELWEIS EGYETEM
EGÉSZSÉGÜGYI
MENEDZSERKÉPZŐ
KÖZPONT

Central and Eastern European Health Net

BASE QUESTIONNAIRE

Out-of-pocket payments for health care in
Hungary

NAME OF INTERVIEWER: _____

NUMBER OF QUESTIONNAIRE: _____

DATE OF COMPLETION: _____ TIME: _____

TELEPHONE NUMBER: _____

ANSWERED:

1. yes

2. refused to answer (sex: male/female)

CAUSE OF REJECTION: _____

NOTES:

MAKE NOTES ON THOSE INTERESTING THINGS CONCERNING THE SUBJECT OF STUDY, WHICH COMES UP DURING THE INTERVIEW, BUT CANNOT BE RECORDED IN THE QUESTIONNAIRE.

1. How old are you (LAST BIRTHDAY)? _____

2. Gender?

1. Female

2. Male

3. Do any other families live in the same accommodation, which manage a separate household (holding a separate budget)?

1. Yes, HOW MANY? ☐

2. No

IF THERE ARE MORE THAN ONE FAMILY, WHO LIVE TOGETHER AND MANAGE A SEPARATE HOUSEHOLD (HOLD A SEPARATE BUDGET), THEN FILL IN SEPARATE BASE QUESTIONNAIRE FOR EACH OF THEM.

ASK WHETHER IT WOULD BE POSSIBLE TO SPEAK WITH ONE MEMBER OF EACH OF THE OTHER FAMILIES.

4. How many of you live in one household including you? _____

5. In the previous FOUR month were you, or somebody living with you in the same household ill, or utilised health care for reasons other than illness, for instance pregnancy, screening, etc?

1. Yes

2. No

Go to question
34

6. In the previous FOUR months ...

...how many of you were ill? _____

...and how many times? _____

...How many of you utilised health services for reasons other than illness?

...and how many times all together? _____

IF THERE WERE MORE THAN ONE PERSON ILL IN THE HOUSEHOLD (OR UTILISED HEALTH SERVICES FOR REASONS OTHER THAN ILLNESS), THEN FILL IN SEPARATE INSERT QUESTIONNAIRE FOR EACH PATIENT, AND IF ONE PATIENT WAS ILL MORE THAN ONCE, THEN FOR EACH ILLNESS EPISODE (OR EPISODE OF UTILISATION).

IN CASE OF MORE THAN ONE PATIENT, DISEASE, OR UTILISATION EPISODE START WITH THE FIRST PATIENTS' FIRST EPISODE AND GO ON ALIKE!

34. What is your opinion about health services provided by the state?

1. Excellent
2. Good
3. Acceptable
4. Unacceptably bad
5. No opinion

34.1 What is your opinion about paying health services directly, out-of-pocket (for instance co-payment in hospitals as in the case of medicines)?

1. Definitely negative
2. Negative
3. Indifferent
4. Supportive, because health workers are insufficiently paid
5. Supportive for other reasons (PLEASE SPECIFY): _____

35. Do you think that co-payments should be introduced for health services that are currently free-of charge?

1. Yes, because we are paying gratuities anyway, so it would just be more transparent
2. Yes, for other reasons (PLEASE SPECIFY): _____
3. No, because today the majority of the population does not pay anything and could not afford to pay anyway
4. No, for other reasons (PLEASE SPECIFY): _____
5. I do not know

36. If you could pay a monthly fee for receiving pharmaceuticals free of charge, how much (maximum) would you be willing to pay?

1. _____ Ft
2. I already pay, the amount paid by YOU _____ Ft
The amount paid by your EMPLOYER _____ Ft
3. No answer

36.1 If you could pay a monthly fee that in case you are ill, gratitude payment is paid instead of you how much (maximum) would you be willing to pay? (MULTIPLE ANSWERS OK)

1. _____ Ft
2. Nothing, because we do not give gratitude payment
3. Nothing, because we have no money
4. Nothing, because we hardly use health services
5. Nothing, because we go to private doctor only
6. Nothing, for other reasons (PLEASE SPECIFY): _____
7. No answer
8. Yes, but only if I could give it directly to the doctor: _____ Ft

37. Please provide us with the following information about you and the other members of your household.

IF THE RESPONDENT MENTIONED A PERSON, WHO DIED DURING TREATMENT, PLEASE TRY TO HAVE DATA ABOUT THIS PERSON AS WELL, INDICATE BESIDE THE CODE FOR *GENDER* WITH AN *H* (FOR INSTANCE 2 H)

	respon- dent	person 1	person 2	person 3	person 4	person 5	person 6	person 7
Sex								
Age								
Marital Status								
Education								
Occupation (MULTIPLE ANSWERS OK)								
Sector (MULTIPLE ANSWERS OK)								
IF YOU FILLED IN AN INSERT QUESTIONNAIRE RELATED TO THIS PERSON, PLEASE RECORD ITS NUMBER HERE!								

CODING scheme:

Sex		Age		Marital status		Education	
Female	1	0-5 years	1	Married	1	incomplete elementary	1
Male	2	6-18 years	2	Partner	2	elementary (8 classes)	2
		19-45 years	3	Widowed	3	secondary vocational	3
Died	H	46-59 years	4	Divorced	4	A levels examination	4
		60 or over <	5	Single	5	postsecondary vocational	5
						higher education	6
						no education	7

Occupation		Not employee	Small private <50 employees	Big private >=50 employees	Public	Other	Sector	
Employee, part time			1	2	3	4	Industry	1
Employee, full time			5	6	7	8	Agriculture	2
Employee, not registered			9	10	11	12	Commerce	3
Self employed	13						Financial sector	4
Pensioner	14						Service industry	5
Student/pupil	15						Health care, public	6
Housewife	16						Health care, private	7
Unemployed	17						Education	8
Child before school age	18						Other public	9
Other dependant	19						Other private	10
Other	20							

IF YOU CHOOSE *OTHER*
PLEASE SPECIFY IT

Now, I will ask you a few questions about the income of your household. Of course answers continue to be voluntary

38. How would you describe the income of your household?

1. Substantially better than average
2. Slightly better than average
3. Average
4. Slightly below average
5. Substantially below average
6. I do not have an opinion

39. How much is the estimated net income of the members of your household together? _____ Ft

IF THE RESPONDENTS DO NOT WANT TO ANSWER, ASK HER/HIM WHETHER HE WOULD RATHER PUT IT IN THE INCOME CATEGORIES BELOW!

1. over 350 thousand
2. 200.001 - 350.000
3. 100.001 - 200.000
4. 50.000 - 100.000
5. below 50 thousand

40. Does your household own?

	Yes, only one	Yes, two or more	No
1. flat or house	1	2	3
2. weekend house	1	2	3
3. car – CEE brand	1	2	3
4. car - West brand)	1	2	3
5. colour TV	1	2	3
6. video recorder	1	2	3
7. mobile phone	1	2	3
8. personal computer	1	2	3
9. refrigerator	1	2	3
10. dish washer	1	2	3

We are very grateful for your participation!

END OF QUESTIONING: _____



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INSERT QUESTIONNAIRE

**Out-of-pocket payments for health care in
Hungary**

**THIS QUESTIONNAIRE HAS TO BE FILLED IN FOR EACH EPISODE OF ILLNESS, OR
UTILISATION OF HEALTH CARE FOR REASONS OTHER THAN ILLNESS!**

NUMBER OF BASE QUESTIONNAIRE / NUMBER OF EPISODE: _____

NOTES:

**MAKE NOTES ON THOSE INTERESTING THINGS CONCERNING THE SUBJECT OF STUDY,
WHICH COMES UP DURING THE INTERVIEW, BUT CANNOT BE RECORDED IN THE
QUESTIONNAIRE**

6.1 What was the health problem? _____

Go to question

7

If not illness, what was the reason of health care utilisation? _____

Go to question

15

7. Did this illness prevent (the person) from continuing his/her normal activities?

1. Yes
2. No

8. If yes, for how long was the ill person unable to continue normal activities?

1. less than one week
2. 7-14 days
3. 14 days – 1 month
4. 1-3 month
5. more than 3 month

9. In Your opinion how serious was this illness?

1. not serious
2. average
3. serious
4. life-threatening

10. For the treatment of this illness, did the person receive any formal care?

1. No
2. Yes

Go to question

13

11. If no formal treatment was sought what were the reasons? (MULTIPLE ANSWERS OK)

1. It was not serious illness
2. Afraid / ashamed to go
3. Not enough money
4. Denied access to care
5. Required services not available in our village/region
6. It served no purpose as treatment is ineffective for this illness
7. Other (PLEASE SPECIFY): _____

12. If purchased medicines, how much did you spend all together? _____ Ft
...or other remedies? _____ Ft
...what were these remedies? _____

...How much did you spend for travel in connection with these? _____ Ft

Go to the next episode of illness, or utilisation with starting a new insert questionnaire,
OR to question 34 on the base questionnaire

13. How long did the person wait before seeking care?

1. looked immediately for a doctor as symptoms noticed
2. this is a chronic illness
3. few hours
4. less than one week
5. one week or more

Go to question
15

14. If treatment was delayed, what were the reasons ? (MULTIPLE ANSWERS OK)

1. It was not serious illness
2. Afraid/ashamed to go
3. Not enough money
4. Health facility is far from where we live
5. thought there was no effective treatment for this illness
6. Other (PLEASE SPECIFY): _____

15. Please specify the health services, which were received in connection with this episode

IF YOU ARE NOT SURE ABOUT CODING, PLEASE MAKE NOTES ABOUT WHAT THE RESPONDENT SAID IN THE COLOUMN 'REMARK'

	Type of care (primary, outpatient specialist, inpatient, etc.)	Type of provider (public /private)	Type of provision (NHIFA financed /private)	Remarks
Provider1				
Provider2				
Provider3				
Provider4				
Provider5				
Provider6				
Provider7				
Provider8				

CODING scheme:

Type of service / levels of care		Type of provider (owner)		Type of provision (who financed?)	
primary care	1	public	1	NHIFA	1
outpatient specialist care	2	private	2	private	2
inpatient care	3	do not know	3	do not know	3
emergency (ambulance, out-of-surgery hours service)	4				
laboratory and other diagnostic service	5				
dental care	6				
other	7				

(PLEASE SPECIFY IN THE TABLE ABOVE, IN COLOUMN 'REMARKS')

16. Why did the person choose that particular provider? (MULTIPLE ANSWERS OK)

IF THERE WERE MORE THAN ONE PROVIDER UTILISED, TAKE THE CODE OF THE PROVIDER FROM QUESTION 15, AND ASK EACH PROVIDER SEPARATELY

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6
Code from question 15:						
1. Closest						
2. Only available for this type of care						
3. Good opinion about particular physician working there						
4. Good reputation of the facility						
5. Previous experience						
6. It was less expensive (for private providers)						
7. Was referred there						
8. His/her family doctor						
9. Others recommended						
10. Other (SPECIFY):						

17. Was the treatment successfully completed?

1. Yes

2. No, it is still going on

3. No, the patient died

4. No
- Go to question 20

18. How was the treatment interrupted? (MULTIPLE ANSWERS OK)

1. did not buy all the drugs that the doctor prescribed

2. bought the medicines, but then did not take them

3. family doctor referred the person to a specialist, but did not follow up

4. family doctor/specialist advised the person to go to a hospital, but did not go

5. doctor said to come back, but the person did not


6. did not follow the diet the doctor prescribed

7. Other (PLEASE SPECIFY)
-

19. If the treatment was interrupted what were the reasons? (MULTIPLE ANSWERS OK)

1. Not enough money
2. Afraid/ashamed to see doctor/go to hospital
3. Required services not available where we live
4. It serves no purpose, treatment is ineffective/inappropriate for this illness
5. Got better the other day
6. Other (PLEASE SPECIFY): _____

20. Was the person satisfied with the medical care received?

1. Yes 

Go to question 21

2. No

With which provider? (RECORD THE CODE(S) OF THE PROVIDER(S) HERE)

20.1 What was the reason of dissatisfaction? (USE THE CODE OF THE PROVIDER, IF MORE THAN ONE)

20.2 Was anything done about this problem?

1. Yes, went to another, public, provider
2. Yes, went to another, private, provider
3. Yes, complained
4. No
5. Other (SPECIFY): _____

20.3 If complained, where? (USE THE CODE OF THE PROVIDER, IF MORE THAN ONE)

21. Was any payment in cash or in kind, any contribution or any gift made for the medical care received?

1. Yes, money

2. Yes, but not money →

Go to question
25

3. No →

Go to question
33

22. How much was paid according to the following categories?

IF THERE WAS MORE THAN ONE PROVIDER UTILISED, TAKE THE CODE OF THE PROVIDER FROM QUESTION 15, AND ASK EACH PROVIDER SEPARATELY

IF THE SAME PROVIDER WAS UTILISED MORE THAN ONCE, THEN ASK FOR ALL THE EXPENSES IN THE PAST FOUR MONTH AND PUT DOWN THE SUM OF THESE PAYMENTS IN THE RELEVANT CELL

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6
Code from question 15:						
1. Admission						
2. Consultation						
3. Pharmaceuticals						
4. Surgery						
5. Nurses and other support staff						
6. Patient transfer						
7. Transportation						
8. Food						
9. Other (SPECIFY):						

22.1 If private services were utilised, was anything given to the physicians or other health workers above (in addition to) the official fee?

1. No

2. Yes, but was not accepted

3. Yes, and it was accepted (APPROXIMATELY HOW MUCH?): Ft

If only private services were utilised (for instance only bought medicine) continue with question 24

23. When was the payment made in relation to the services? (MULTIPLE ANSWERS OK)

IF THERE WAS MORE THAN ONE PROVIDER UTILISED, TAKE THE CODE OF THE PROVIDER FROM QUESTION 15, AND ASK EACH PROVIDER SEPARATELY
LEAVE OUT PRIVATE SERVICES

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6
Code from question 15:						
1. before treatment						
2. during treatment (if more than one visit)						
3. after treatment						

24. Was anything given (except for money) to the physician or other health workers?

1. Yes
2. No

Go to question
27

25. Please specify what was given? (MULTIPLE ANSWERS OK)

1. Did a favour (SPECIFY) _____
2. Flower
3. Alcoholic drink
4. Sweets
5. Other (SPECIFY) _____

26. Please assess the money equivalent of these, according to the service in connection which they were given

IF THERE WAS MORE THAN ONE PROVIDER UTILISED, TAKE THE CODE OF THE PROVIDER FROM QUESTION 15, AND ASK EACH PROVIDER SEPARATELY

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	Provider 6
Code from question 15:						
1. Admission						
2. Consultation						
3. Surgery						
4. Nurses and other support staff						
5. Other (SPECIFY)						
6. Total						

**If utilised free services and gave money or gift then continue with question 27 ...
...otherwise go to question 31!**

27. Why were the additional contribution made? (MULTIPLE ANSWERS OK)

1. was grateful
2. it is customary
3. it was forced
4. expedite treatment
5. obtain more attention from doctor
6. obtain more attention from nurse
7. obtain better quality medicines
8. establish good relationship with physician for future treatment
9. extra hotel services (single room, TV in room, better food, etc)
10. physician provided sick leave certificate
11. physician provided disability certificate
12. other (SPECIFY): _____

28. Do you feel that the payment was forced at the medical facility?

1. Yes
2. No
3. Uncertain

29. If utilised free services, did it occur that patient (or relatives) had to provide part of the services during treatment?

1. Yes

2. No _____

**Go to question
31**

30. If yes, what were these, and approximately how much did they cost?

1. Pharmaceuticals: _____ Ft
2. Patient supervision, nursing: _____ Ft
3. Other (SPECIFY) _____
_____ Ft

31. How much did you spend altogether in connection with this episode of care?
_____ Ft

32. How were the funds, used to pay for treatment, obtained?

	Yes	No
1. From cash revenue	1	2
2. Household savings	1	2
3. Sale of family assets (jewellery, house, car, etc.)	1	2
4. Gift form a person outside the household	1	2
5. Loan from a bank or person outside the household	1	2
6. Other (SPECIFY): _____	1	2

If utilised free services and did not give money or gift then continue with question 33
otherwise
go to the next episode of illness, or utilisation with starting a new insert questionnaire,
OR to question 34 on the base questionnaire!

33. You told me that the services were not paid for, why? (MULTIPLE ANSWERS OK)

- 1. Paid by the government
- 2. paid by social insurance
- 3. paid by private insurance
- 4. doctor is a friend
- 5. other (SPECIFY): _____

Go to the next episode of illness, or utilisation with starting a new insert questionnaire,
OR to question 34 on the base questionnaire!



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INSTRUCTIONS

**for interviewers for filling in the questionnaire for
out-of-pocket payments for health care in Hungary**

General instructions

1. The questionnaire has to be filled using telephone interviews for all persons living in the same household. If possible start questioning after 6 pm, because it is more probable that you will find the head of the household (or other competent person) at home then.
2. Please note the questions, where **MULTIPLE ANSWERS** are acceptable.
3. After dialling the number, and the phone is answered provide a brief introduction into the project, and try to speak to the head of the household or other competent person.

In connection with the introduction of the project, you should mention the following points:

- *introduction, person and organisation (Semmelweis University, HSMTC, Budapest)*
- *sorry for bothering the person unknowingly, we have selected the phone numbers randomly*
- *the objective of the research is to assess out-of-pocket payments for health care*
- *the research is implemented in an international collaboration including five academic institutions and four countries*
- *participation is entirely voluntary*
- *the information obtained during the research will be handled strictly confidentially, and the participants anonymity will be preserved*
- *we would like to use the results to contribute to the improvement of the performance of the health care system*

Ask the person:

- *whether he or she would be willing to participate*
 - *whether he or she lives there and would be able to provide information on household issues; if not can he or she send somebody, who would (for instance a child his or her parents)*
 - *whether he or she would be able to spend approximately 15-25 minutes to answer the questions*
 - *if yes is it suitable now, or call him or her at a more convenient time*
4. Please make notes on if the respondent did not understand the question, had comments which did not fit in the questionnaire, or answers, which did not fit in the predefined answers, etc.
 5. If the respondent refused to participate, try to ask him or her about the reasons, and record the answer on the front page of the base questionnaire
 6. If the phone were not answered, record the date and time of unsuccessful attempts on the cover page of the base questionnaire.

Instructions for specific questions

Question 15

- At this question the most important is to identify the pure private services (private provider paid out-of-pocket). Generally the people know this.
- If the respondent is not sure whether he or she utilised publicly (NHIFA) financed services, then ask whether his or her social insurance identification card was requested at the provider.
- All state/local government owned health care provider are public.
- The category of public provider – private provision (financing) include those services that are not financed by the NHIFA, but provided by public providers as well (for instance laser vision correction surgery), and private practice in public institutions. In this latter category the distinguishing feature is that the patient pays a predetermined fee, set by the physician.
- In primary care entrepreneur family doctors count private, even if the surgery is owned by the local government.

Questions on money paid, gifts and in kind contribution given, always consider expenses for the LAST FOUR MONTH, which precedes the interview.

Question 22

- If the patient concerned utilised the same provider more than once during the past four month, then ask for the sum of all the expenses in the past FOUR MONTH.

Question 23

- This question, of course, does not apply to 'pure' private services.

Question 26

- If the patient concerned utilised the same provider more than once during the past four month, then ask for the sum of all the expenses in the past FOUR MONTH.

Question 27-30

- These questions, of course, do not apply to 'pure' private services.

Question 34

- If the answer to this question is not consistent with experiences of actual episodes of illness then make notes on what the respondent complains about.

D.5. Formal out-of-pocket payments in Hungary and the operationalisation of informal payment

Formal and informal payments have been separated during the analytical phase of the study, using the knowledge on formal co-payments (Table D11), the data obtained on health care providers, and on the payment for various service categories.

Table D11. Formal out-of-pocket payments in the Hungarian health care system in the first half of 2001

Item	Amount		Who determines the amount?	Remarks
Pharmaceuticals	0, 50, 70, 90, 100%, or fixed		price negotiations	price subsidy
Medical aids and prosthesis (including dental prostheses)	50,70, 85, 100% or fixed			price subsidy
Balneotherapy	85 or 100%			price subsidy
Treatment in sanatorium (rehabilitation)	per diem		government	co-payment*
Tooth preserving dental care	cost of materials (filling); can be 10% higher for those not attending regular check up		provider	co-payment**
Above standard hotel services				
room	per diem		provider	co-payment
meal	difference between the cost of standard meals and what is required		provider	co-payment
Utilization of more services, than what is ordered by the doctor	difference between the cost of materials of the required service and what was medically indicated, including extra patient days		provider	co-payment
Inappropriate utilization of services: without referral (1) at other provider, where the patient has been referred to (2)	(1)	(2)	government, provider can increase the amount up to 30%	co-payment
outpatient specialist care	2000 HUF	1500 HUF		
acute inpatient care admission	4000 HUF	4000 HUF		
until the 31st day	1000 HUF/day	800 HUF/day		
after the 31st day	500 HUF/day	400 HUF/day		
chronic inpatient care admission	4000 HUF	4000 HUF		
until the 31st day	600 HUF/day	500 HUF/day		
after the 31st day	400 HUF/day	400 HUF/day		
long term care admission	4000 HUF	4000 HUF		
for the duration of stay	1000 HUF/day	400 HUF/day		
Chronic long term care according to referral	400 HUF/day***		government	co-payment
Medical certificate for driving license	800-8000 HUF		government	full cost
Medical certificate for shot gun license	3000-9000 HUF		government	full cost
Blood alcohol test	3500 HUF		government	full cost
Medical certificate for forensic purposes	2000 HUF		government	full cost
Detoxifying	5000 HUF		government	full cost
Transport of drunk people	600 HUF/km		government	full cost
Other excluded services, like cosmetic surgery	prices varies		provider	price
Services which are utilized at a provider with no NHIFA contract	price varies		provider	price

Notes: *Currently there are no rules in effect, which would determine the extent of co-payment. **Abolished, as of 1 November, 2001. ***Before 1998 it was determined on the basis of the minimum pension, and greater flexibility was allowed to providers, to deviate from the centrally set co-payment.

Sources:[2; 131; 3]

We have applied the following rules:

- Given that during the period of data collection, a substantial co-payment had to be paid for public dental services, all dental payments were considered formal.

- The same applied for the category of pharmaceutical expenditures.
- Expenditures on food were considered formal, except for publicly financed inpatient care, but the single case of this kind was recategorized as in kind contribution.
- The category of 'other expenses' was recoded according to the additional information, the respondent gave on the nature of the expense. The rest of other expenses with publicly financed service were considered informal.
- All other categories were considered informal if the service (provider) was said to be publicly financed.
- Because of the existence of conditional formal co-payments, the expenditures on admission were intended to be considered on a case by case basis, but given that there was only one case of this kind, and the respondent did not want to tell the amount, the categorization of payment on admissions did not cause any problem.

It has to be noted, that the above operationalisation of informal payment is not perfect. First, it is possible that patient paid the dentists informally, but because it is up to providers to decide on the amount of co-payment, and because of the lack of information on how many and what kind of treatments were made, it is not possible to separate formal and informal. This might lead to an underestimation of the amount of informal payment. Second, it is not certain that respondents have made a clear distinction between payment and in kind contribution in cases when in kind contribution has had to be bought, for instance pharmaceuticals and meals. Also it is possible that the respondents' perception of entitlement for services is not exactly the same as it is defined by the law. For instance bringing in meals to hospitals is quite common in Hungary, but there could be patients who do not realize that this is an in kind contribution.⁶⁵ These factors could lead to the underestimation of in kind contribution or double counting, but since there have been only few cases of in kind contribution, double counting seems to be a negligible problem.

⁶⁵ Also, these are not 'typical', 'common sense' health care expenditures.

APPENDIX E.

E. THE HISTORY OF INFORMAL PAYMENT: POLICY MAKING AND ACADEMIC DEBATES

On the basis of historical documents Ádám [50; 49; 8] gives a detailed account of the history of informal payment in the Hungarian health care system. The following points are a brief summary of his findings. Other authors, such as Szabó [194; 72], Balázs [236; 237; 154; 73] and Antal [153] have also written on this topic, especially Balázs, who discussed extensively the history of remuneration of physicians. Where relevant Ádám's historical analysis is complemented or confronted with comments from them, but the theories of the origin and causes of informal payment will be elaborated in chapter 4.

E.1. The origins of informal payment in the Hungarian health care system

According to Ádám [50; 49,pp.56-61], informal payment was an unknown phenomenon before World War II. He argued that the spreading of informal payment as a problem was first mentioned in the autumn of 1948 and it subsequently occupied a key position in the health policy agenda. Balázs [73] somewhat challenged this view, referring to a quotation from 1942 about illegal private practice in hospitals. He argued that informal payment had emerged when the publicly employed physician used equipment and supplies of the hospital for private surgery and received a fee for the service from patients, as if he was a private practitioner. Nevertheless, Ádám [49,pp.57-58,61,79] pointed out that before 1942 private practice in hospitals was not at all illegal, and there were only a few posts in public service, such as chief medical officers, that had prohibitions on private practice. Moreover, senior consultants in hospitals paid a certain percentage of the fee they earned from private practice into a so-called 'pay box' ('petty cash'), from which other contributors were compensated for their work. New graduates, the so-called 'unpaid trainees' lived solely from this income, but Ádám [49,p.57] argued that these payments were informal (illegal), insofar as they were not admitted to, to avoid paying tax.

Balázs [154,pp.27-28] also argued that during the 1930s, exercising their market power to press down physicians' fee, insurance companies were as important as the state in the development of a situation that later led to the emergence of informal payment. But because it took time, this situation only unfolded fully during the communist regime. This argument certainly has some validity but we should not forget that, in this period, the physicians' fee was negotiable even if the patient had private insurance [50].

Nevertheless, Balázs was not the only one who thought that it was misleading to link informal payment to the communist regime. Writers on medical ethics, such as Szabó [72] saw informal payment as part of the culture of Hungarian society, and argued that it was impossible to forbid people to give gifts. In contrast, Ádám pointed out that in-kind contributions from peasants in villages and rural areas should not be confused with informal payment, since peasants were usually short of cash so it was much simpler for them to pay in kind to settle a legitimate bill. The regulation of the National Medical

Chamber on medical practice and minimum fees in 1939 said that "*contributions in kind must be valued according to the market price on the day it is due*" [49,pp.57-58].

E.2. The policy of gratitude payment

Ádám [50] argued, that the initial 'tipping' of health workers was emerged in the 1950s, and although informal payment had never been approved officially during this state-socialist period, government actions created an ambiguous situation [49,pp.62-213]. First, informal payment was included in the calculation of physicians' salaries. This measure meant that those specialities that were regarded as 'non-paying' (i.e. where informal payment was rare or non-existent) received somewhat higher salaries than the 'paying' ones. The "*compensation*" policy began as early as 1950 [49,p.82]. Second, gratitude payment was separated from other types of informal payment, such as selling of beds or cheating with sickness benefits. Gratitude payment was defined as voluntarily given by patients, after treatment, as an expression of gratitude, but not in exchange for exceptional services. In the fight against gratitude payment, legal penalties were rejected by the communist party [50,p.65]. Third, according to the policy of 'separate treatment', all subsequent laws and regulations were designed so that they did not sanction the acceptance of gratitude payment. In summary, Ádám concluded, that as a result of the blurred wording of relevant laws, and the reluctance of officials to declare its unacceptability, the belief that gratitude payment was legal became widespread both among doctors and patients. As he put it, a "*phantom law*" was born [49,p.197]. It is not surprising, he argued, that none of the four official campaigns against gratitude payment proved to be successful [49,pp.98-133,144-148,171-182,232-233] and that the number of proceedings associated with any type of informal payment rapidly decreased over time. Between 1958 and 1962 a total of 373 cases were reported and the corresponding figure between 1980 and 1984 was 29 [49,pp.139,194-196]. Finally, in 1988, just before the political changes, the government decided to tax gratitude payment [187; 188,17(7); 8,pp.58-91].

E.3. Informal payment and the reform era

Since then, no further direct governmental intervention has been proposed to tackle the issue. National health policies in the new reform era are remarkably consistent in how they view informal payments [189]. The phenomenon is undesirable, but its elimination can be envisaged only in the long term, with the exclusive use of indirect measures [37; 38,p.190].

Nevertheless 1998 seemed to bring about noticeable changes in policy making when the minister of health of the new government seriously challenged informal payment in his first speeches. He set up a committee from leading experts of the field, including Balázs, Ádám, Bondár, Bordás and Tóth, to propose a solution to the problem. This initiative, however, had no visible effect on policy making. The report of the so-called 'Gratitude Payment Committee' was eventually published [384], and policy returned to its previous track. The reasons why these experts were unable to influence policy making has not yet been analysed, but it would be unfair to blame it all on short-sighted and self interested politicians. The academic debate about the role and nature of informal payment has long been contentious, and the waves of debate characterised by much polemic.

E.4. Academic debates and scientific research

In Hungary scientific research on informal payment dates back to the 1970s, initially with the aim of supporting official policies. The findings of the first empirical research studies were published in *Népegészségügy* [Public Health], the official journal of the MOH [e.g.77; 78; 82; 190; 80]. These papers were accompanied by articles on medical ethics, which echoed the official policy of separating the corrupt and non-corrupt forms of informal payment on the basis of the cultural origin of the phenomenon [e.g.191; 192-194]. These arguments characterised theoretical discussion during the 1970s, but the issue was at least on the research agenda.

In parallel with the softening political climate in the 1980s, a second wave of academic debates on the columns of two sociological journals, *Valóság* [Reality] and *Társadalmi Szemle* [Social Review], enriched the discussion with approaches that explicitly criticised the system, emphasising the social, economic and legal aspects of informal payment [85; 195; 65; 196; 70; 66; 197].⁶⁶

The intensive debates received a new push at the beginning of the 1990s when expectations of reforms were articulated [e.g.202; 64; 71; and subsequent discussion in *Replika* 63; 9; 52; 69; 203; 153], but the nature of informal payment remained contentious with confronting views on the desirable policy measures to address the phenomenon [e.g.39; and 63; vs. 68; or 52; vs. 69].

Finally, the establishment of the 'Gratitude Payment Committee' initiated a new surge of public debate between 1998 and 2000, and gave a new push to scientific research of the phenomenon, but positions remained as diverse and contradictory as before [214].⁶⁷

The early studies have generated some empirical evidence concerning the scale of informal payment and the motivation of patients and doctors, but these are often inconclusive and contradictory, too. More importantly, some of its main characteristics, such as the impact of informal payment on health services, their nature, causes and roles, the potential obstruction to the reform and the policy options that might tackle the problem remain relatively un-researched. The lack of empirical evidence is undoubtedly a source of debates around the issue and it is not surprising that these debates had little influence on policy-making. Although Balázs [211] rather sarcastically concluded that the history of informal payment in health policy consisted of lack of knowledge combined with inappropriate measures, the reluctance of politicians to act more explicitly in a rather blurred situation characterised by insufficient and inconclusive evidence, and contrasting expert opinions, does not seem to be irrational. Indeed, this thesis aims to take one step back to try to clarify the situation from theory to empirical evidence.

⁶⁶ For empirical research in this period see for instance Bánlaky et al. [198] Antal [199; 159], Szabó [83], Ékes [200], Dobossy et al. [79], Hungarian Central Statistical Office [201].

⁶⁷ After more than a decade, this research was the first of its kind, which had informal payment in its focus.

APPENDIX F.

F. THE DEFINITION OF INFORMAL PAYMENT

So far we have talked about informal payment without discussing what precisely informal payment is. This appendix aims to make up for this shortage drawing on not just the Hungarian, but the broader, international literature. Unfortunately, there is no generally accepted definition of informal payments [96], so it is necessary to look at the issue in more depth.

The international literature contains at least as much controversy as seen in the debates in Hungary. It seems that the conceptualisation of informal payments is influenced by the specificities of the countries that the researchers draw their experiences from. Even the terms used to denote the phenomenon vary greatly: gratuities or gratitude payments [67], envelope payments [204], under-the-counter payments [74], unofficial payments [103], under-the-table payments [101] to name but a few. The proposed terms and definitions, which emphasize for instance 'illegality' and 'corruption' as the distinctive feature of informal payment, may accurately reflect the situation within a country, or a particular set of countries, but not applicable across all countries. More importantly, however, they reflect certain assumptions on the nature of the phenomenon (why patients give, is it good or bad), which are not necessary true in all cases and consequently may mislead policy-makers. This is not to say that the characteristics implied by these terms are not part of the phenomenon. Indeed, informal payments have shown to be heterogeneous with many faces, from sweets and flowers to "*brick payments*", from small tips to enormous amounts for a single operation [104; 96; 101; 95]. But behind these seemingly diverse images, we argue, it is possible to find a common defining criterion which fulfils three requirements. First, that it is scientifically neutral, i.e. it remains free from any judgments and assumptions concerning the reasons for and desirability of the phenomenon. Second, it is consistent, i.e. it is able to separate informal payments from other ('formal') payments, so that the same phenomenon is consistently included or excluded across all countries and within a particular country over time. Third, that it is broad enough to capture the diversity of the phenomenon, i.e. it includes all observed variants of informal payments.

This appendix reviews the various forms of informal payment reported from various countries, examines definitions proposed so far, and suggests an alternative definition, which advocates that entitlements to health services, determined by laws and regulations, should be the key defining criteria to delimit informal payments in each country. Then we discuss the boundaries of informal payment implied by our definition and the implications for the current study and for research on the phenomenon in general.

F.1. Images of informal payment: a theme with variations

In Hungary the most common image of informal payments for health care is that of physicians being paid by patients who utilise health services that should be free of charge in the public system. For instance, Balázs [189] defined the phenomenon as an informal purchase, whereby patients in fact buy a service from the publicly employed physician. This definition, however, does not only assume that informal payment is

paid in exchange for a service (or a better service), which is debated, but restricts the richness of the phenomenon in two respects. First, it limits the discussion to monetary transfers, so disregarding in-kind transactions. Second, it reduces the scope of possible actors to patients and physicians, excluding other actors such as other health workers or provider institutions. Whilst this definition may reflect the dominant form of informal payments in Hungary, there is considerable evidence to suggest that it is certainly not applicable to many other countries [96].

Moreover, even Hungarian researchers argued against restricting informal payments to monetary transfers, overlooking goods and services as media of transaction [85; 9]. These 'in-kind' informal payments range from tangible gifts, such as sweets or alcoholic drinks, but also more expensive items such as works of art or jewellery, to services provided by the patients or their relatives, and political favours, which Buda called the *"darkest form of informal payment"* [9]. In many former socialist countries [104], barter had special relevance during the communist regime, when chronic shortages characterized several sectors of the centrally planned economy. As Petschnig [85] put it: *"in these cases the various jobs, which are taking place at different locations and different times, are in fact exchanged. Shortages such as bricklayers and car mechanics, are closely coupled with medicine."* Beside these *"direct natural exchanges"*, she also distinguished another form of barter, *"indirect natural exchange"*, whereby physicians were provided a (future) political quid pro quo, such as promotion, withdrawal of charges, and judicial proceedings stopped [85; 9].

International experiences not only strengthen the case for including in-kind payments as an important form of informal payments, but also establish another in-kind variant of the phenomenon. These are goods and services, which should be part of the service, but which patients must provide for themselves, including meals, bedding, clean laundry, medical supplies, pharmaceuticals and even diagnostic tests [102; 96; 104; 103]. A lack of nursing services may also be compensated for by work of relatives of patients [101].

The other shortcoming of Balázs's definition is that it fails to account for those informal payments that involve actors other than patients and physicians. Possible participants in such transactions include not just individuals, but also institutions, not just patients (users of the services), but their relatives and not just the doctor, but other health workers as well. Buda [9] for example noted how in Hungary *"corporations, institutions often supported a particular hospital: they helped to purchase important medical equipment; nowadays they pay money into the foundation [charity] set up by the hospital... This is (was) informal payment with a vengeance."* In Poland Shahriari et al [104,pp.4,11,18,21] found that the most 'popular' form of additional payments by patients was the so-called *"brick payment"*. Patients and relatives were invited to buy a token brick for a certain sum, by which means they supported the health care institution. In the study by Shahriari et al [104,p.18], all episodes of hospitalisation involved purchase of such a 'brick'. Furthermore, the World Health Report 2000 refers to *"informal charging"* a widespread phenomenon, whereby health care providers set fees for services that should be provided free of charge [58,p.xv].

In addition to the method of payment (what is given?) and the participants in the transactions (by whom, to whom?), many researchers have described other forms of informal payment on the basis of other dimensions, such as the timing and location of the transaction (when and where?), and the motivation of the actors (why?) [101; 102; 96; 104]. For instance Shahriari et al. [104,pp.10,18] reported so-called *"advance*

payments", which were made by patients to specialists in their private surgery, not for the private visit, but to gain subsequent admission to a public hospital that was otherwise free of charge. Another classic example is the so-called "gratuities" or "gratitude payments", defined as patients thanking physicians for their services entirely voluntarily after the treatment, a phenomenon often thought to have deep cultural roots [67; 96,pp.3,10; 104,pp.4,10,17,21]. Others have looked at the size of the payment as a means to separate *tips*, which are usually a small amount of money compared to the actual cost of the service [50].

Table F1. Images of informal payment

	Informal charging	Advance payment	Brick payment	Tip	In kind contribution	Gratuity
Who gives?						
individuals (patients, relatives)	x	x	x	x	x	x
institutions (businesses, governmental organisations)						
To whom?						
individuals (physicians, nurses, administrators)	x	x		x		x
health care institutions	x		x		x	
What?						
money	x	x	x	x		x
in kind: non-medical items and services (e.g. sweets, spirits, flowers, favours)						x
in kind: health service related items and services (e.g. bedding, meals, drugs, nursing)					x	
How much?						
small amounts	?	?	?	x	?	?
large amounts	?	?	?		?	?
When?						
before the service	?	x	?		x	
during the service	?		?		x	
after the service	?		?	x		x
Where?						
on site	x		x	x	x	x
not on site		x				
Why?						
to obtain the desired care/service, enforced	x	?	?		x	
to obtain the desired care/service, voluntary		?	?			
gratitude (voluntary)			?	?		x

These examples clearly illustrate the considerable diversity of the phenomenon, showing how it is far from straightforward to develop a comprehensive typology of informal payments. Ensor [95] acknowledges this diversity by defining informal payments on the basis of the three functions they serve. Table F1 summarises the dimensions discussed before, and places some of the aforementioned examples into the framework.

However, some of the dimensions used to distinguish between different forms of informal payment may be questionable. For instance many researchers have noted the difficulty in interpreting 'before' and 'after' in health care [85; 49; 9; 74; 96]. Buda [9] argued that, most obviously, the concept is untenable is primary care, where the relationship between doctor and patient is usually long-lasting, whilst McKee and Chenet [385] have drawn attention to the challenges involved in defining single episodes of care in relation to the growing amount of chronic diseases that require continuous treatment. Another example is gratitude as a motivation factor. Researchers have pointed out the difficulty of separating gratuities from other forms of informal payment [96; 104], whilst others debated even the validity of the gratitude payment concept [85; 67]. We shall return to this issue later.

But what is the key defining feature that delimits the boundaries of a phenomenon with so many different images? What is the common feature of advance payments and brick payments, of clean bedding, drugs or meals provided by relatives of the patient and a bottle of whisky, or a half-pig given to the doctor? To answer this question we first examine some of the definitions of informal payment proposed so far, and point out the shortcomings of the distinctive characteristics these definitions imply.

F.2. Definitions of informal payment

There are few attempts in the literature to formulate a precise definition of informal payments, because the exact nature of informal payment is often taken for granted. Table F2 provides an overview of the definitions available in the literature. We have highlighted the distinctive characteristics that each definition uses to separate informal payments from other, related phenomena.

Table F2. Proposed definitions of informal payment

Source (country)	Definition	Distinctive characteristics
Ádám, 1989 [67,Hungary]	"A <i>gratuity</i> may be defined as a financial or other material benefit, given to the doctor voluntarily by a patient or his or her relatives after treatment has been terminated."	voluntary
Balázs, 1996 [189,Hungary]	"... <i>medical gratitude payment</i> is an informal money transaction between the doctor and the patient, in the course of which the patient purchase a health service from the <i>publicly</i> employed doctor."	informal purchase; public
Chawla, 2000 [cited in 104,Poland]	"... <i>payments</i> , in cash or in kind, made by patients, or others on behalf of the patients, to an individual or institutional public health care provider directly or to any person arranging for provision of health care from such <i>public</i> health care providers, for health services received or expected to be received, that the recipients of these payments are not authorized to receive under existing laws of the land, including the Constitution of Poland, 1997, and the Health Insurance Act, 1997, or under the rules of business of the health facility."	illegality; public
Thompson, 2000 [102]	" <i>Informal payments</i> can be described as payments made by individuals to <i>state</i> health workers or institutions but which are not sanctioned by the authorities".	not sanctioned by the authorities; public (state)
Lewis, 2000 [96]	" <i>Informal payments</i> can be defined as (1) payments to individual and institutional providers, in kind or in cash, that are made outside official payment channels and (2) purchases that are meant to be covered by the health care system. ... In effect informal payments are a form of corruption."	unofficial, corruption
Ensor, 2004 [95]	" <i>Informal payments</i> fall into three categories: cost contributions, including supplies and salaries, misuse of market position and payments for additional services."	various functions: contribution, corruption, purchase

Each of these definitions has certain shortcomings. Some of them include the author's own interpretation of the phenomenon, for instance disputed assumptions on why people give [see 67; 189; 96; 95]. Others focus on a particular form of informal payment within countries, not on the entire phenomenon [see 67; 189]. Although Ensor [95] tries to overcome this problem by defining informal payments by their different functions in different settings, but still, none of these definitions consistently incorporate all observed variants of informal payment across different countries. We argue that none of the distinctive features implied by these definitions are able to provide a consistent basis to discriminate between informal payments and other phenomena.

To unfold this argument first we need to clarify the meaning of certain concepts, for which we draw on the wider literature on the informal economy. Voluntary or compulsory, formal or informal, legal or illegal, official or unofficial are concepts that somehow are all connected to the presence and activities of the state [230], but these terms are not defined precisely and consequently their usage is a source of confusion. For instance Shahriari et al. [104,p.10] argued that the definition of Chawla (2000) implies that informal and illegal payments are the same, whilst there are certain forms of informal payment that are not illegal but are nonetheless unreported. This terminological confusion is not specific to the health sector, but characterises in general the study of the 'informal' or 'hidden' economy [230; 386].

F.2.1. WHAT IS THE DIFFERENCE BETWEEN 'INFORMAL' AND 'ILLEGAL'?

One of the few things on which writers on the 'informal' or 'hidden' economy agree is that the literature is fraught with terminological and conceptual confusion [230; 386]. There are several terms that have been coined to describe the whole phenomenon or its various components, ranging from the hidden or underground economy to various shades of economies (black, gray etc.). As Harding and Jenkins [230] point out, the only common element in the description of informal economic activities seems to be that such activities are not registered by the state. On the basis of this observation, we draw the first distinction according to the nature and the scope of public registration. An economic activity is 'informal' if it is, according to Ferman and Berndt [387; cited in 230], not registered by the economic measurement techniques of society, or as Lewis [96,p.8] put it, unaudited and unreported.

The second distinction, which separates 'legal' and 'illegal', is linked to another activity of the state: regulation. Researchers such as Dallago [386] remind us that the state does not just record economic activity, but also influences it by setting rules that should be complied with.

Dallago [386,pp.XV-XXI,3-17] distinguishes four different parts of the economy (regular, informal, irregular and criminal) based on two dimensions: the purpose of the activity (more specifically the goods or services concerned), and the means of achieving that purpose. The irregular economy encompasses those economic activities whose goal is permitted, but the rules set by the state are deliberately infringed in the pursuit of that goal. As Dallago [386,p.XIX] puts it: "...the irregular economy displays a discrepancy between economic goals – which are permitted – and the 'rule-breaking' instruments and means used to achieve them." In the case of the criminal economy neither the aims nor the means are legal. Thus, for example the production of iron bars

employing unregistered workers is considered irregular, whilst trading illicit drugs is criminal.

For our purpose, the key distinction is between 'informal' and 'illegal'. There are certain economic activities that are informal, i.e. not registered by the state, but not illegal in that they do not contravene the established laws and regulations, for instance production for self-consumption and barter. Informality and illegality do not necessary coincide, with informal payments for health care offering a good example [104].

F.2.2. INFORMAL PAYMENT=ILLEGAL PAYMENT?

Using these definitions and distinctions we argue that neither informality nor illegality are sufficient criteria to embrace all observed forms of informal payments. The legal assessment of the various forms of the phenomenon differs not just between countries, but even within a particular country over time. For instance, informal payments paid to physicians and other health workers (*"envelope payments"*) may be illegal in Poland [Chawla, 2000 cited in 104], but since 1989 they must be reported in tax returns in Hungary [8]. Furthermore, Hungary offers a good example of how the legality of informal payments changed over time. In his historical analysis, Ádám [49,pp.83,93-95] shows how all forms of informal payments made to doctors became illegal once physicians became civil servants during the nationalisation process implemented by the communist regime in the 1950s. In 1979, however, this situation changed, and only those doctors who were authorised to make clinical decisions autonomously (enjoyed the so-called 'right of disposition') were prohibited from accepting informal payments [49,pp.183-189].

Another complication is that the 'de jure' situation does not always coincide with the 'de facto' one. Regulations may not be implemented or enforced by the government, or most members of society may not comply with them so that enforcement is impossible. Thus illegality does not always imply illegitimacy, with the history of informal payments in Hungary again offering a good illustration. Ádám [66; 49] argued that, during the communist regime, the statements of policy makers created an ambiguous situation concerning informal payments, which made patients and doctors believe that ex post 'thank you' payments (gratuities) were not prohibited although, formally, they were illegal. This policy allowed the regime to shift part of the cost burden of care to patients and so compensate for the inadequacy of public finance. Moreover, policy makers not only condoned an illegal practice, but attempted to adjust subsequent legislation in a way that tolerated gratitude payment, although, as Ádám [67] argued, the criminal law was not changed and informal payments remained illegal throughout this period. In addition, the policy of *"banned in principle, but permitted in practice"* had legal consequences, since Hungarian laws precluded punishment if the person acted in the belief that the action was not harmful to the society [67; 49,pp.213-214]. The discrepancy between the 'de jure' and 'de facto' situation, so common in many transitional countries, highlights the limitations of the *"not sanctioned by the authorities"* criterion adopted by Thompson and Witter [102] to define informal payments. If *"sanctioned"* means permitted 'de jure' then this criterion is only a different phrasing of illegality. If *"sanctioned"* means 'de facto', then the same phenomenon may be classified as informal payments in one country and not in another, depending on the attitude of policy makers and effectiveness of enforcement. It should, however, be noted that Thompson and Witter acknowledge this problem and coin a new

term, "*quasi formal payments*", covering those payments that are illegal but tolerated by policy makers.

F.2.3. IS INFORMAL PAYMENT REALLY INFORMAL?

Informality is not a good defining criterion either. There are certain payments, not registered by the state, but excluded by researchers from the phenomenon. For instance, voluntary purchases from private providers are not, in essence, informal payments [96,p.1], even if these are informal in the sense that they are not accounted for by the provider to avoid paying tax. Conversely, there are certain informal payments that are not informal in the sense that they are reported and registered. For instance, the declaration of informal payments in the tax returns of health workers in Hungary virtually makes informal payments formal. Another good example is the aforementioned advance payments, reported by Shahriari et al. [104] in Poland. If the private practitioner reports these payments to the tax authorities as part of his or her income, they become 'formal', although advance payments are informal in that they are paid to gain admission to a public hospital that levies no formal charges. Neither do brick payments and other payments to charities and foundations established by health care institutions fulfil the informality criterion if these funds are established and managed according to the legal framework effective in the country concerned. Certain in-kind contributions, such as food or pharmaceuticals, may also be formal if purchased by the patients or their relatives, although these should have been supplied by the health care provider itself.

The above examples clearly illustrate the point that neither illegality nor informality are distinctive characteristics of the phenomenon, consequently they do not provide criteria that will describe all varieties of informal payments observed by researchers. Even the same form of informal payment would fit into any categories of Dallago's model, from the formal to the criminal economy, depending on the attitudes and policies of the authorities of different countries.

One could argue, however, that if not all forms of informal payments are informal in the sense that they are unreported and unaudited, the usage of the term 'informal payment' creates confusion. We acknowledge this problem, but recognise that there is an emerging consensus in favour of this approach amongst researchers [97; 205; 102; 104; 93; 95]. In fact, the major advantage of the term 'informal payment' is that it is neutral: it does not imply any preconception concerning the 'morality' (desirability) of the phenomenon. The term 'unofficial' could be an alternative, insofar as it is also neutral, but it would give rise to the same potential confusions. Is 'unofficial' simply a rephrasing of informality or illegality, or is it a different concept? Unfortunately, the authors did not clarify the exact meaning of unofficial in their publications [96; 103].

F.2.4. ENFORCED BY CORRUPT PUBLIC SERVANTS?

Finally, we should discuss the identification of informal payments with corruption. The detailed discussion of corruption is beyond the scope of this thesis, but the suggestion that corruption should be the defining characteristic of informal payments merits attention because Lewis [96] and Shahriari et al [104] imply that it is a separate concept that can be differentiated from illegality and informality.

In her definition, Lewis does not provide an explanation what *"official payment channels"* mean, but she argues that informal payments created *"an informal market for health care within the confines of the public health care service network"*, and *"in effect are a form of corruption"* [96,p.1]. She reinforces this view of informal payments when she raises the problem of distinguishing between informal payments and gratitude payments, emphasising the importance of whether payment is discretionary or required. The same point was put forward by Shahriari et al. [104,p.10], who argued that the distinction between formal and informal payments was not clear cut, in part because *"the line between a voluntary gift and a coercive payment is hard to draw"*. This approach suggests that payments should be considered informal, if there is some degree of coercion from the provider side, which they exercise to further their own interests at the expense of the public interest. As Lewis [96,p.4] argued *"informal payments... provide a means by which corrupt public servants can ensure or maximize their income, evade taxes, and effectively 'beat the system'"*, and consequently *"are a form of systemic corruption"*.

If we adopt 'pursuing one's private interests at the expense of public interest' as a working definition of corruption, it is not difficult to show how it is different from illegality. If rules are not detailed or straightforward, clear cases of corruption may not be illegal. In contrast, illegality does not indicate corruption when the rules are ignored or bypassed in the public interest. Moreover, the general public may not be aware of certain regulations or, as has been mentioned before, disregard them, if the rules set by the state do not coincide with the norms of society. According to these considerations informal payments would in fact be 'corrupt payments', which benefit a few physicians and patients, leaving the rest worse-off, regardless of the actual informality or illegality of the phenomenon. We are talking about both providers and users, as, contrary to the position taken by Lewis [96], there is no reason to assume that only providers can have corrupt intentions.

Nonetheless, we argue that equating informal payments with corruption is inadequate to incorporate all observed forms of the phenomenon, even if we set aside the gratitude payment debate, and for now assume that gratuities are not true informal payments. There are a number of examples of informal payments that are difficult to fit into the framework of corruption, for instance in-kind contributions. Even Shahriari et al [104,p.10] acknowledge that *"there is a difference between payments from which providers directly benefit, and those that reflect... the dire financial situation of the institution"*, and refer to the example of bringing one's own clean linen and food during hospital stays. Nonetheless one can argue in defence of the corruption definition in that cost-shifting to patients, in the form of inadequate medical supplies and other support services, could well be an income maximising strategy on the part of health care providers, inasmuch as the 'savings' realised this way can be channelled to the remuneration of health care workers. Examples from many developing and transitional countries [96; 103], however, identify a more fundamental problem with the corruption framework. For instance Lewis [96,p.5] cites Georgia, Ukraine and the Russian Federation, where salaries of health workers have not only plummeted, but non-payment is also common. In these circumstances the alternative to informal charging is leaving one's job, which would result in the total collapse of the system. Given the alternative, it is difficult to argue that 'no service' is more in the public interest than a system that delivers services, even if users have to pay. This is especially so if the

benefits spill over to the poor, if health care providers price-discriminate according to their patients' ability to pay. We argue that stigmatising patients and health workers as corrupt in these extreme circumstances does not help policy-makers, but rather diverts attention from the heart of the problem. Whilst Lewis [96,p.4] argues that "*corrupt public servants*" effectively "*beat the system*", it is the system (the government) that 'has beaten first'. Patients and doctors simply adapted to the rules of the game.

This is not to say that corruption is not part of the phenomenon, but that it is not the distinctive characteristic of informal payments. In a system where insufficient funding undermines the legitimacy of regulations set by the government, the interpretation by individual patients and service providers about what is acceptable and what is not can vary considerably. Indeed, there are certain informal payments whose corrupt nature would be difficult to deny. Thompson and Witter [102,p.179] reported that, in the former Soviet Union, different terms were used to differentiate physicians being paid informally for what they were "*supposed to do*" as opposed to what they were "*not supposed to do*". In Hungary, Buda [9,pp.83-84] argued that official discussions were dominated by the gratitude payment concept, but primary care was the obvious example where gratitude payment was blatantly interconnected with corruption. He argued that in primary care, the patient-doctor relationship was continuous and informal payments were often made for example to obtain medical certificates for sickness leave, or referral to certain specialists or hospitals. As he put it, informal payments made to general practitioners were "*the 'socialist' skeleton that could not be hidden in the cupboard*" [9,p.84].

Acknowledging the importance of this issue, we argue that the role of coercion versus 'thanksgiving', corruption or legitimacy is central to the understanding of the nature of the phenomenon, and its impact on system performance, but these criteria, along with illegality and informality, are not adequate to formulate a coherent and measurable definition of informal payment. Then what is the characteristic that is common to all forms of informal payments described so far?

F.2.5. ENTITLEMENTS: AN ALTERNATIVE DEFINITION OF INFORMAL PAYMENT

We argue that the regulatory activity of the state plays an important part in the definition of informal payments, but not that they determine legality or illegality. Regulations are important insofar as they determine what services patients should receive in exchange for what, a concept that we call 'entitlement'. We argue that all forms of informal payments involve some form of direct contribution by patients or their households in addition to what is formally required, i.e. what the terms of entitlement determine. 'Contribution' refers to any form of payment, in cash or in-kind, which is made in addition to anything required legally, while 'direct' means that this contribution is borne directly by the patients or their households as opposed to third parties, such as private health insurance, compulsory social insurance and taxation.⁶⁸ Informal payments are a subset of out-of-pocket contributions, the distinguishing

⁶⁸ Eventually, all health care costs are borne by households, insofar as prepaid private insurance premiums, social insurance contributions and taxes also come from households, but there is a significant difference in terms of economic incidence, i.e. how the costs of health services are distributed among various population groups, particularly between the sick and the healthy. All forms of out-of-pocket payments fall directly on the sick, whilst prepaid schemes spread the cost burden of health care to include the healthy.

characteristic being that formal out-of-pocket payments are stipulated in the terms of entitlements, whilst informal payments are made in addition to them.

Hence, the distinctive characteristic of informal payments is this 'superfluous' characteristic of the contribution, whether utilisation is free of charge or a direct contribution set out in the terms of health care entitlements. This approach implies that, from the perspective of definition of informal payments, it is immaterial whether a particular form of informal payment is legal or registered (formal) in a particular country. What shifts a direct payment from the category of informal payments to the category of other direct payments, or vice versa, is any change in the existing entitlements to health services.

Accordingly, informal payment for health care can be defined more precisely as:

'a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or those acting on behalf of patients, to health care providers for services which the patients are entitled to'.

Again, we stress that the distinctive feature of informal payment is that it is additional to the legally defined terms of entitlement, which describes those services that can be utilized by patients, what these services comprise and how much out-of-pocket payment has to be paid. It must be noted, however, that legally defined does not necessarily mean that entitlements to health services are regulated in detail by law. Entitlements can be defined by several actors in the health care system and not just the government. For instance in the private sector, private providers or insurance companies are allowed to define what patients get in exchange for what, even if there are certain restrictions imposed on them by centrally determined regulations. It is also possible in a public system that providers are allowed to collect co-payments from users of services. According to the definition proposed here, the reference point for determining whether a direct contribution is a formal or informal payment is the formal terms of entitlement, regardless of who sets them.

The advantage of this definition is that it consistently encompasses all described forms of informal payments, such as envelope, advance and brick payments, gifts, or the in kind provision of drugs, nursing or meals during inpatient care, and does not attempt to explain why patients give and whether informal payments are good or bad.

It is important to note, however, that the boundaries of informal payments set by this definition imply a number of inclusions and exclusions. We have already mentioned voluntary purchases from private providers, which are not accounted for by the provider to avoid paying tax. In accordance with Lewis [96], these are excluded by our definition, too. In the subsequent sections, we explore exclusions and inclusions in more detail.

F.2.6. PUBLIC OR PRIVATE?

Most of the definitions listed in Table F2 see informal payments as exclusive to the public sector; payments to public providers only. Balázs [211] went even further by arguing that it was conceptual absurdity to talk about informal payments in a purely private setting. Why would patients pay more out of their pocket than the price that the private practitioner charges?

In contrast, our definition does not exclude informal payments in the private sector. In principle, it is possible that patients pay more to a private provider than the predetermined fee, even if there is no obvious reason why they would do so. We argue, however, that this depends on how one explains informal payments. If the gratitude payment concept is valid and it is a norm embedded in the culture of the society to make gifts to health care providers to thank them for being cured, it would be illogical to claim that patients are only grateful to public and not private providers. Indeed, informal payments in the private sector are a neglected, but theoretically possible option, whose empirical study would yield important evidence concerning the validity of the gratitude payment concept. Moreover, fee setting in the private sector can be subject to regulatory restrictions imposed by the state, which may also generate informal payments.

A sharp separation of the public and the private sector does not accurately reflect the findings of studies that report increasingly blurred boundaries between the two sectors, not just in terms of informal payments, but concerning the development of the private sector in general [104,p.4]. The collapse of the communist regime in the countries of the former Soviet bloc opened the way for the development of a private sector, but in many ways this development was interlinked with the public sector rather than separated from it. In most of these countries the 'skeleton' of the Semashko system remained in place, but the flesh on the bones, the muscles, which move the system are rather a delicate mixture of public and private than a 'clean' public 'tissue'. Advance payments are a good example, whereby a separate part-time private practice is used to 'sell' public services provided by the same physician in the public institution. Part time private practice can also take place in public institutions, but not necessarily illegally. For instance, in Poland so-called "*medical foundations*" have been established, which hire the facilities, equipment and even the personnel from the public provider to offer services privately, with the designated working hours being the only difference between the public and the private service [104]. However, whether any specific services are offered in 'normal' working hours, and should thus be provided for free, or whether they are regularly offered and directly paid for as part of physicians' intra-mural private activity in extra-time, is increasingly difficult to determine. Public employment also provides opportunities to recruit, or sometimes even to force patients into private practice [104,pp.13,21; 103]. These practices do not only underpin the argument that informal payments can cross the line between the public and the private sector, but offer examples of phenomena that are not informal payments, according to not just our, but any proposed definition, although they are closely related to them.

F.2.7. INFORMAL PAYMENT AND INFORMAL ECONOMIC ACTIVITY

Our definition does exclude a number of informal activities that are not informal payments; nonetheless they can have similar implications as informal payment itself on policy making. For instance, illegal private practice in public institutions or forcing patients to go to private practice do not fit the criteria of informal payments, if patients do not pay more than physicians ask for. A wide range of related provider activities have been reported by McPake et al. [98] in Uganda, from pilfering of drug supplies and misuse of formal revenues to rarely showing up during official working hours. On the patients' side, using social connections may be an example, which, beside cash and in-

kind payments, Shahriari et al [104,p.24] categorise as *"other means to ensure access to quality care"*.

The recognition that informal payment is part of a wider category of 'informal economic activities' is important for understanding the nature and boundaries of the phenomenon, especially why people give. We shall revisit this issue, when the theories of informal payment are discussed.

F.2.8. GRATUITIES: VOLUNTARY GIFTS?

Our definition deliberately ignores the motivation of the actors and the timing of the transaction, and therefore it does not exclude gratuities. However, as has been mentioned before, the differentiation between voluntary contributions by patients as opposed to those enforced by the provider, and between ex ante and ex post payments, is a recurring theme in debates on the phenomenon not just amongst researchers but also policy makers, giving rise to the idea that gratuities are not informal payments in the strict sense, or at least that they should be treated separately [66; 50; 67; 96; 104]. Indeed, a culturally determined 'thanksgiving' that has no adverse effect on equity and efficiency, but may improve provider responsiveness, and as suggested by Shahriari et al. [104,p.4], has markedly different implications for policy making than a payment that is enforced where, if there is non payment, access is denied. It is doubtful, though, whether gratuities really exist in a 'pure' form, or whether it is possible to separate them from informal payments.

F.2.8.1 Before and after

The difficulty of interpreting 'before' and 'after' in health care has already been pointed out [85; 49; 9; 74], whilst the examples of advance payments, barter and political favours have illustrated that the phenomenon is not constrained by time and space [85; 9; 104,p.18]. In Hungary, Petschnig [85] explicitly denied the validity of the concept of gratitude payments. As she put it: *"gratitude payment is a fee to obtain personal gains even if paid after the service."* Buda [9] went further by arguing that the gratitude payment concept served ideological purposes, justifying the official policy of virtual approval, which had many beneficiaries including the government. It kept a potentially powerful group (physicians) silent and it eased the financial pressure on the health care system by shifting some of the financial burden implicitly to patients.

F.2.8.2 The phases of financial hardship and images of informal payment

We argue that the conceptual confusion around this issue is partly attributable to that the state-socialist past of former communist countries being largely ignored. Whilst the available cross-country comparative analyses stress the causal link between the hardship caused by insufficient financial resources and informal payments, they consider gratuities as a pre-transition cultural tradition in these countries [96; 102]. The recognition that similar, but perhaps weaker and less visible forces worked during the communist period helps us to refine the overall conclusion of Lewis that the collapse of the communist regime led to the rapid exacerbation of the problem in most countries of the region, and why Slovenia and the Czech Republic may be exceptions [96,pp.1,3,5].

If we take the idea of insufficient funding as a starting point in our analysis, a simple model can be drawn up which relates the scale of lack of resources to the various forms

of informal payments observed (Table F3). Phases of 'decompensation' range from sufficient funding with no informal payments at one extreme to the other where virtually no funding is available so that even salaries are unpaid and providers openly charge patients. Of course these schematic phases can and do overlap in reality.

There are two basic assumptions in this model. First, that there is a clear ranking in 'cost saving' methods in line with the extent of under funding. It ranges from reductions that do not have immediate effect on the supply of services, such as investment costs and some element of salaries, to reductions that make it impossible to maintain services even in the short run, such as resources to pay for essential supplies and a basic level of salaries. Second, that there is a ranking of legitimacy, in other words what type of informal payments are seen as acceptable by providers in relation to the extent of funding inadequacy. The more desperate the situation is, the less providers are disturbed about using coercion. We argue that different types of informal payment are means of compensation for inadequate funding. The appearance of a new form of informal payments may be the first sign that the system is decompensating and moving to another phase.

Table F3.

Hypothesised association between the extent of funding insufficiency and the forms of informal payment

	Gifts, tips	Cash payment to staff, barter	In-kind contribution	Cash payment to institutional providers
Adequate funding, but uniform provision	x			
Investment costs (training, equipment, building)		x		
Salaries-1: low		x		
Medical supplies, ancillary services			x	
Salaries-2: arrears, non-payment				x

The examples cited by Lewis [96], in one of the most comprehensive cross-country comparison of informal payments so far, seem to fit well in this framework. Lewis [96,pp.3,5] argues that informal payments have been reported from all countries of CEE and the FSU, with the exception of Slovenia and Czech Republic, where health care salaries kept pace with inflation and remained above the national average. However, other sources suggest that informal payments did exist in the Czech Republic during the communist period, as in other former communist countries [218]. Whilst total, and within them publicly funded health care expenditures were more homogenous among communist countries, levels of health care spending are now extremely diverse (Table F4). Health care spending has increased in Slovenia, Czech Republic, Hungary and Poland and declined in Russia, Ukraine, Georgia and Kazakhstan, leaving Slovenia and the Czech Republic by far the highest spenders on health care in the region. Furthermore, within the high spending group a large gap has developed between these first two countries and Hungary, and a less marked, but still noticeable gap remained between Poland and Hungary. In Table F4, 1991 is used as a proxy for the communist period, because of the limitations of data availability in previous years. It is likely that the divergence would be even more marked if more appropriate data were available.

For instance in Hungary the establishment of social insurance funding in 1990, brought about a substantial increase in health care expenditures. While in 1989 purchasing-power adjusted per capita health expenditures were US\$325, the corresponding figure for 1990 was US\$510 [107]. To provide another example, in 1994, PPP-adjusted public per capita health expenditures were US\$9 in Ukraine and US\$65 in Kazakhstan.

Table F4. Health care expenditures in selected countries (in PPP US\$)

COUNTRY	1991		1999	
	Public	Total	Public	Total
Slovenia	311	311	1058	1230
Czech Republic	485	539	899	983
Hungary	436	501	575	767
Poland	224	296	402	535
Russia	...	383	...	209
Ukraine	...	171	...	107
Georgia	...	165	...	105
Kazakhstan	195	198	...	104

Source: [107]

These trends correspond well with the forms of informal payments observed in these countries. There are no or few informal payments in the Czech Republic and Slovenia [96,pp.5-6], whilst informal charging is commonplace in Georgia and Ukraine, where non-payment of salaries is common [96,p.5]. In the Russian Federation salaries are often in arrears and informal payments are estimated as 56% of total health care expenditure [96,pp.5,19]. Hungary and Poland lie somewhere in the middle with low salaries among the health workforce compared to other sectors of the economy, and cash payments, mainly to medical doctors, as the dominant form of informal payments [67; 204]. There is, however, a difference between the two countries. In-kind contributions (lack of medical supplies) have been reported from Poland, but not from Hungary [104].

F.2.8.3 The 'coercion factor', trust and the social capital of health care

Another source of conceptual confusion concerning gratuities is what differentiates voluntary payments from payments that are enforced. We argue that coercion should be given a wider interpretation, which goes beyond the narrow provider focus implied by Lewis [96] and Shahriari et al. [104,p.21]. The desire of patients to get better care than they expect the system will deliver is in itself a reflection of pressure for payment, even if providers do not, subtly or otherwise, demand (enforce) informal payments.

The distrust of patients in the ability of the system to deliver adequate services, in terms of quality and timing, without paying, does not necessarily have to come from the patients' own experiences. It may reflect a society-wide dissatisfaction with public services, which makes people suspicious about what they can expect to receive. For instance Lewis [96,p.18] reported that a survey in the Russian Federation found that a quarter of the respondents used private care, because *"they lacked confidence in the professional qualifications of public employee physicians."* In health care, matters are complicated further in that patients' ability to judge the clinical quality of services is limited by the information asymmetry between patients and physicians. Consequently it is possible that patients may perceive a problem to exist even if the system delivers

adequate service, implying that trust is very difficult to build up again, once it has been lost.

Ensor and Witter [103] put forward a plausible hypothesis concerning the success of financial risk sharing schemes in low income countries, where the informal sector is large and initiatives must build on voluntary participation. They argue that the sustainability of local financing initiatives is insufficiently explained by the peculiarities of individual behaviour in voluntary health insurance markets, such as adverse selection, observed in wealthier countries. At least equally important is the challenge to policy makers from what they call *"an understandable distrust of official schemes"*, as *"individuals may ask the question: if I put my money into this insurance fund, will it still be there when I fall ill and need it?"* They argue that in these circumstances the success of community financing depends on how much the local initiative is able to win support from the members of the community, by involving people and developing shared values, a key tenet of social capital theories. If building this social capital is successful, people seem willing to pay more than the benefits they anticipate.

We suggest extending this argument to service provision. If social capital is eroded by a long-term discrepancy between what has been promised and what is delivered, patients rightly ask the question: 'If I use public services, will I receive the care that I need?'. We argue that this distrust (or loss of social capital) pressurises patients to pay 'voluntarily', at least as much as direct pressure by providers. It is this 'coercion' that distinguishes other forms of informal payments from gratitude payments. Moreover, the concept of distrust suggests that informal payments cannot successfully be eliminated in the absence of measures aimed at restoring social capital. Indeed, the lack of social capital can be invoked as a plausible factor in explaining the extent of informal payments in CEE and FSU countries. Informal payments and informal economic activities may be considered part of a more general distrust in government, contributing to a degree of disintegration of society. This is akin to what Ensor and Witter call a *"culture of individualism"*, characterised by the expansion of the informal sector. However, the extent to which social capital was lost has varied, reflecting differences in pathways of transition. Some countries were able to achieve stability and subsequently improve their situation, whilst others were trapped in a vicious downward cycle. Expansion of the informal sector led to shrinkage of government revenues, which led to a deterioration in public services, leading to an increasing illegitimacy of government established regulations in the eyes of both providers, who were not paid, and users of services, who did not get what they wanted. This further eroded the trust in the public system for two reasons. First, negative views among users of services were reinforced, and second, providers considered it increasingly legitimate to manipulate the services for their own benefit. These factors contributed to the further expansion of the informal sector and a decline in public revenues and so on.

F.2.8.4 Gifts? Coercion by users

In addition to coercion, another issue requiring clarification in respect of gratuities is what constitutes a gift, in terms of what is given and why it is given? The gratitude payment concept assumes that, as Szabó [72] put it, there is a part of a physician's work that it is *"not possible to pay for"*. If this is true, then cash payments made to health workers seem to be incompatible with the concept of a gift. Moreover, it suggests that gift giving is a unilateral process, so that gifts are not given in exchange for something.

If gifts are given openly so that the receiver knows who the giver is, then it is very difficult to exclude reciprocity and the creation of an obligation in the relationship. This makes it difficult to distinguish true gratuities from other forms of informal payments based on real or perceived exchanges. Indeed, researchers often overlook how patients may seek to create obligations by giving, to offset the power of the physician. As Field [388; cited in 102] put it, informal payments "*constitute a countervailing power at the disposal of the patient to exert some control over the physician*". One can only be absolutely sure that a 'pure' gift has been given if the giver does not reveal her identity, which has echoes of the biblical injunction to: "*Take care not to perform righteous deeds in order that people may see them... When you give alms, do not blow trumpet before you, as the hypocrites do... to win the praise of others... But when you give alms, do not let your left hand know what your right is doing...*" [389,Mt.6,1-4]. This is certainly not typical of gratitude payments in health care.

Nonetheless, the validity of the gratitude payment concept remains a question that should be explored by empirical research. It is rarely sufficient to conclude whether a gift was given voluntarily or was (in its wider sense) coerced from knowledge of what is given, when and to whom. Empirical research on this issue should address the motivation of actors, which remains a key distinguishing characteristic of 'true' gratuities.

F.4. Implications for research: operationalisation of informal payment

Whilst the above conceptualisation of informal payment provides a starting point for its study even in an international context, it is not obvious how to put the definition into practice. The difficulty of operationalisation relates to the problems of obtaining appropriate data that will permit separation of formal and informal payments, as well as of the various forms of the phenomenon.

The sources of data on informal payments are ultimately the participants of the transactions, including patients, households and individual and institutional providers. Lewis [96,p.10] argues that, in countries where informal payments are illegal, providers are reluctant to admit or discuss informal payments. If the illegality of the phenomenon is clear this probably applies equally to patients. Nonetheless providers have a good reason to deny informal payments even in countries where they are not illegal, if providers conceal their income from informal payments to avoid paying tax. This suggests that patients and households are generally better sources of information, which may explain why published quantitative studies have so far almost exclusively targeted the user side [96,pp.11-13; 102].

The complexity of the task of separating formal and informal payments reflects the difficulty in assessing whether entitlements are clear to the various actors, and to what extent formal and informal payments coexist in the same system, in particular for the same service. There are two possible ways to operationalise informal payments. First, patients can be asked directly to distinguish formal and informal payments. Second, it is possible to ask respondents how much they spent (contributed) according to different type of services and different type of providers, and then researchers have to 'distill out' informal payments on the basis of total out-of-pocket payments reported and of the

knowledge of existing formal direct payments determined by the laws and regulations in the health care system under study.

If entitlements, including the level of co-payments, are laid down centrally and apply equally to all health care providers, the indirect method can work well, since the identification of informal payments is not different for different providers and does not rely on patients' own interpretation. Moreover, if questions do not directly address informal payments it may be possible to obtain a better response, given the sensitive nature of the topic. Conversely, as systems increasingly decentralize decisions about terms of entitlement, researchers increasingly rely on patients to separate the formal from the informal, since it is increasingly difficult to distinguish informal payment when formal co-payments are widespread and individual providers are allowed to set them freely, or at least within broad limits. However, if patients are asked directly, there is a risk that the individuals' perception of what constitutes an informal payment does not coincide with the above proposed conceptualization. For instance, in Hungary, the most widely used term to denote the phenomenon is gratitude payment but this has always been a source of confusion [67; 9]. One group of patients may consider only 'true' gratitude payments, while others include payments for better care. Furthermore, the direct method assumes that patients know what they are entitled to, but evidence has shown that patients are often confused about their health entitlements, especially if there are frequent changes in the health care system [96,p.16; 102; 104,p.10]. Patients may not be aware of co-payments introduced for previously free services, or may not question charges, even if services remained free of charge.

Further difficulties arise when it comes to the separation of the various forms of informal payments. The distinction between in-kind contributions and cash payments is not straightforward as certain in-kind contributions, such as pharmaceuticals, may need to be paid for, even if ultimately they are provided in-kind. More importantly, as discussed before, gratitude payments are not easy to distinguish, and quantitative methods alone may be insufficient to capture the motivation of the actors. As Lewis [96,p.14] argues, qualitative methods are important to explore motivation, which is difficult to assess in surveys.

F.5. Conclusions

Reviewing the varieties of informal payment reported from various countries, we have concluded that none of the proposed definitions provides a consistent criterion to separate informal payments from other direct contributions. The alternative definition, suggested here, identifies informal payment as a direct contribution that is in addition to what has been defined by the terms of entitlement, and this 'additional' nature of informal payment is the distinctive characteristic that separates 'informal' from other 'formal' out-of-pocket payments. We have argued that this definition provides a consistent boundary that is able to incorporate the various forms of informal payments described so far, across countries and within countries over time, as opposed to other criteria such as informality, illegality and corruption, which are prone to inconsistent categorisation and may imply value judgements and unverified assumptions concerning the nature of the phenomenon.

The proposed definition delimits the boundaries of the phenomenon, which implies certain inclusions and exclusions. It excludes fees that are not reported by the private

provider to avoid paying tax, whilst it does not exclude the possibility of informal payments in the private sector. It excludes certain informal economic activities, such as coercing patients to use private practice, or undertaking illegal private practice in public institutions, but it includes gratuities, gifts and donations. However, both create certain ambiguities. One can argue that giving is an accepted social activity, whose implications differ from payments coerced and consequently should not be included. In contrast, the excluded informal economic activities are similar to informal payments in their implications for policy making. Here we have argued that policy making should take a wider focus that includes all informal economic activities, only one form of which is informal payment. On the other hand, we acknowledge that voluntary donations and coerced payments have different implications, but these should rather be seen as different explanations than different forms of informal payment and require verification by empirical research. In any case, coercion should be given a wider interpretation both on the providers' and the users' side.

Discussing the implications of the definition on the current study and on empirical research in general we have concluded that the operationalisation of informal payments is a complex task. Both the direct and the indirect methods of separating formal and informal payments are prone to miscategorization. There seems no unambiguously ideal way to operationalise the concept of informal payments, as important aspects of formality or informality, legality or illegality, terms of entitlement and the existence of formal out-of-pocket payments vary between countries.

Nonetheless, conceptualisation in a way that makes it possible to incorporate the findings of existing empirical studies is the first step towards understanding informal payments and so providing an empirical basis for new effective policies to tackle the phenomenon. The proposed new definition emphasises the additional contribution above what the user is required to make. This raises the question of 'why people give more than is required?' Is informal payment the product of a tradition of 'giving thanks' or culture of 'gifts'? Is it because people are unaware of what they are entitled to? Or is it because the health care system is not able to deliver what has been promised? The answers to these questions are crucial for policy makers, not only because they determine what should and may be done about informal payments, but also whether it is necessary to do anything at all. The next chapter addresses exactly these issues in more detail, invoking the concepts of gratitude payment and coercion raised in this chapter.

APPENDIX G.

G. THEORIES OF THE ORIGIN OF INFORMAL PAYMENTS

The causes of informal payment in the Hungarian health care system have been subject to intensive debates ever since it became a legitimate topic of scientific research. The various explanations and causal factors, which are presented in Table G1 in three main categories: legal-ethical, social-cultural, and economic, were put forward in two major waves.⁶⁹

Causes of the emergence of informal payment in the Hungarian health care system

Casual factor	Source
SOCIAL-CULTURAL	
Gratitude, tipping	[194; 207]
Development of people's attitudes lagged behind	[208]
LEGAL-ETHICAL	
Low morale of the medical profession (individualistic/petty bourgeois approach)	[192]
Voluntarism of the 1950's (community-centred approach)	[390; 195]
Lack of control and accountability	[66; 50; 49; 65]
ECONOMIC	
Demand-side factors	
Freeness – infinite demand	[85]
Freeness - excess demand	[202]
Restriction of consumer sovereignty – decreased purchasing power	[70; 109]
Sudden increase in demand for health care	[49]
Restriction of consumer sovereignty - the lack of free choice of provider, lack of trust, fear and anxiety	[70; 196; 109; 71]
Supply-side factors	
Macroeconomic policy did not prefer the health sector	[70; 202; 40; 52]
Inappropriate payment methods of providers (institutions and physicians)	[52]
Low salary of physicians (health workers)	[391; 208; 70; 66; 50; 49]

During the 1970s the theoretical discussion was dominated by the social-cultural and ethical explanations of informal payment. These theories provided scientific underpinnings for the official policy, which did not acknowledge that informal payments had anything to do with the construct and operation of the Semashko system itself. During the 1980s, however, the regime had increasingly permitted the publication of critical views, which introduced the legal and economic explanations into the dispute. These causal factors explicitly linked informal payments to the failures of the health care system, or openly criticised the official policy of 'no direct action'.

G.1. Social-cultural explanations of informal payments

According to Ádám [50; 49] the origins of informal payment in the Hungarian health care system can be traced back to the end of the 1940s, when the new state-socialist

⁶⁹ Table 4.1 presents the hypothesised casual factors with their most prominent advocates, although it must be noted that most commentators see informal payment as a phenomenon with multiple causes.

model was established (chapter 2). During this period the official policy of the communist party gradually took shape, separating 'tipping' from corrupt practices, such as selling beds, and cheating with sickness benefits. While the former was tolerated, the latter should have been eradicated by means of administrative (legal) measures.

Early theoretical discussions reflected this duality, introducing ethical and social-cultural explanations of informal payment. Toleration of informal payment was justified by social-cultural factors, namely the custom of tipping and the gratitude motive, as Szabó [72,p.285] put it: *"We must accept that tipping and presentation existed in the past and will be with us in the future for a long time, too. It is impossible to forbid people to give gifts"*. The proponents of this 'gift giving' or 'gratitude payment' approach argued that the work of physicians has a part, which *"cannot be paid for [sic]"*. Healing traditionally leads to a sense of gratitude, and recovered patients express this in the form of gifts. This is part of national culture, rooted in ancient traditions of votive offerings [72,pp.61-68; 203]. More recent writers, such as Kornai [207,p.105] also emphasized the historical origin of informal payment, regarding informal payment as a special form of tipping.⁷⁰ Whilst some argued for making a clear distinction between tipping and gift giving, since the habit of tipping had developed in a traditional master-servant relationship [50], whether informal payment is considered a gratitude payment or a tip, it is thought to be part of the culture of the society and consequently its origin predates the establishment of the state-socialist health care system.

The cultural dimension of the phenomenon was further elaborated by Magyar, who interpreted informal payment within the concept of social evolution. He argued that people were unable adapt to the achievements of the communist regime so their attitude to free access *"lagged behind"* in the earlier feudal-capitalist society [208,p.140]. Unlike the gratitude payment concept, this argument was rarely used to underpin official party policy, but common to all three approaches is that they explain informal payment in social-cultural terms and imply that it is very difficult to change. This clearly differs from the legal-ethical and economic explanations, which offer the prospect of achievable solutions in the short term.

G.2. Legal-ethical explanations of informal payment

The essence of the legal-ethical explanation is that informal payment is a moral issue, with clear legal consequences. The earliest approach emphasized the low morals of the medical profession, in which they not just accepted informal payments, but actively extract them from the patients. As Lukáts [192] put it, physicians were *"philistine (petty bourgeois)"* and individualistic by nature, i.e. they selfishly worked for themselves (rather than the community). This argument was an important element of the early attitude of the communist party, which, according to Ádám [49:,p.86], regarded the medical profession as a *"counterrevolutionary gang"*, and justified the harsh treatment of physicians when it came to the determination of salaries.

⁷⁰ Other authors, such as Balázs, also questioned the direct link between informal payment and the communist regime. Nevertheless, Balázs [73] was discussing illegal practice in public hospitals as a pre-communist phenomenon, not informal payment per se.

Nevertheless, the ethical approach was later used to justify the acceptance of informal payment along with the concept of gratitude. Writers on medical ethics distinguished the various circumstances in which the acceptance of informal payment was not immoral, most obviously if it was given without prompting, by grateful patients, and even certain cases, when there was a perceived obligation to accept [193; 194]. The ethical approach coupled with the cultural explanation of the gratitude motive has persisted ever since and it is still the dominant view among the representatives of the medical profession [86].

Of course, the possibility that low moral standards among Hungarian physicians might explain informal payment was fiercely denied by the profession and was also rejected by many later theorists [391; 390: 212; 85; 66], some of whom rejected the relevance of the ethical approach altogether. The critique of the ethical perspective came from three directions, all of which expressed some criticism of the regime.

Levendel argued that the cause of informal payment was not the individualism of physicians, but the "*voluntarism*" of the 1950s. The regime expected people to work for the sake of the community and not for themselves (i.e. to accept a poor salary) and the rejection of this view led to the emergence of informal payment [390; 195].

In contrast, Ádám and Blasszauer emphasized lack of control and accountability, thereby pushing the ethical discussion into the realm of law. Although Blasszauer [65] did not explicitly question the distinction between gratitude payment and more obviously corrupt practices, he pointed out the failure to use legal sanctions in even the most extreme cases of informal payment. Ádám [66; 49,p.76] extended this argument by explicitly denying that the various forms of informal payment could meaningfully be separated in practice and emphasized the legal ambiguity surrounding the problem as the main cause of informal payment. On the basis of comparison with other health care systems, he concluded that the only unique feature of the Hungarian system was the official toleration of informal payment, even though it had never been legally permitted [66]. He argued that the authorities deliberately failed to enforce the law in order to avoid paying physicians an adequate salary. It was this official disregard of the law that made informal payment widespread.

Finally, Petschnig [85] also criticized the ethical approach to the problem and introduced a third group of casual factors into the discussion, which tried to explain the emergence of informal payment according to economic principles.

G.3. Economic explanations of informal payment

The common feature of both the social-cultural and the legal-ethical explanations is that they do not necessarily imply any problem with the health care system itself. Petschnig [85] challenged this view by identifying shortage as the principal cause of informal payment. Obviously the regime did not want to admit this and sought to exclude an economic interpretation for decades. Although the medical profession had argued that their low salaries were a key factor from the beginning of the communist period, this was not seen as being linked to poor health system performance. As Weil put it: "*There is no higher morale than the socialist ethics. We must implement this among physicians...We have been talking about a lot, that tipping is thriving among health workers... The cause is the same: the salary of physicians is so low, that it cannot ensure an adequate living standard*" [1948 cited in 49,p.76]. Nevertheless, Petschnig

[85] denied the role of low salaries in the genesis of informal payment on the grounds that acceptance is secondary to giving, and that patients did not know how much doctors earned. Instead, with her famous assertion "*Freeness makes ill!*", she argued that free access to health services, with the implied infinite demand leading to an artificial shortage was responsible for the problem.

While shortage is central to all economic theories of informal payment, Petschnig's idea of "*infinite demand*" was later criticised by many researchers [70; 202]. Galasi and Kertesi [202] argued that the demand for health services was not just constrained by user charges, but associated costs of utilization, such as the pain and discomfort of interventions and costs of obtaining information, travel, and lost time. On the other hand, Petschnig's idea of artificial shortage, which is essentially an argument for demand side moral hazard, again does not imply a problem in the supply of health services. As a response to Petschnig's article Kuti [70] introduced the supply side arguments into the economic debate. Criticising the concept of infinite demand, she argued that demand could be satisfied if the development of the health care sector had been given priority, but "*the socialist planned economy did not favour health care investments*". Citing Marschall she saw two reasons for the 'unfavourable investment policy'. First, health care was regarded as an "*unproductive*" sector of the economy and second, it was financed from the central government budget.

The inadequate supply argument was subsequently supported by other writers, including Ádám [49], Szalai [40], Galasi and Kertesi [202], Bordás [52]. Ádám [49,pp.83-85] elaborated this argument by pointing to the sudden increase in the demand for health care as the immediate cause of inadequate supply. He argued that, during the establishment of the state-socialist health care system, the population covered increased rapidly, in large increments that were not followed by corresponding increases in capacity.

Kuti [70] also saw two other sources of shortage. First, she pointed out that the regime defined wages and salaries of people in the context of "*freeness*" of health services, so decreasing the purchasing power of patients (consumers), while it failed to provide what they really wanted. Patients had been deprived of consumer sovereignty, including free choice of doctor and institution. She argued that trust between physicians and patients was a key ingredient of effective treatment and it was unlikely to develop if patients are denied choice. Indeed, she argued, the function of informal payment was partly to create the opportunity of free choice of physician and health care institution. The restriction of consumer sovereignty argument and, within it, lack of free choice of provider, were advocated by others, such as Bóc [196]. Losonczy [109] and Antal [71] extended the argument by identifying the defencelessness of the patients and the anxiety accompanying medical interventions as key motivating factors in giving informal payment. Antal [71] argued that "*fear has an important role in the period of preparation for giving birth... hence various rumours... have a peculiar (demand inducer) role, since for the time being only gratitude payment is able to defend them against these fears...*", and later on that "*mothers try to alleviate their overwhelming defencelessness with money...*". In contrast, Galasi and Kertesi [202] questioned whether the consumer sovereignty argument had any relevance to the emergence of informal payment. They accepted the importance of trust, insofar as information asymmetry between patients and physicians made health care an experience or credence

good, but rejected the special emphasis on free choice other than it was part of consumers' unsatisfied wants.

Beside the consumer sovereignty argument, the second innovation in Kuti's explanation was that she rejected Petschnig's view that low salaries were only of secondary importance in the genesis of informal payment. Kuti [70] argued that low salaries alone could have led to the emergence of the phenomenon inasmuch as they induced shortage. First, what Kuti called the "*honest*" physician's behaviour meant that physicians had to work overtime or take up second or third part-time jobs to make ends meet, so that the quality of their work declined, often creating an impression of carelessness to patients. Second, what she called "*immoral behaviour*" meant that some physicians organised the provision of services to encourage, elicit or even force payment. Galasi and Kertesi [202] challenged this latter proposition on the grounds that physician could not demand informal payments unless the idea had taken roots and become a routine feature of the system. Instead they argued that excess demand and insufficient resources together created a disequilibrium that the system could not resolve.

Finally, Bordás [52] extended the supply side explanation even further. He argued that, regardless of the actual level of physician salaries, salaries and line item budgets were inappropriate payment mechanisms since they did not provide any incentives to increase productivity.

G.4. Summary of various explanations

In summary, the various theories concerning the causes of informal payment can be classified into three main groups, each of which has markedly different implications for policy responses. The cultural explanation assumes a never ending struggle with few or no effective tools in the hand of policy makers, whilst the economic and legal-ethical explanations offer feasible responses within a reasonable time period, even if the implied policy measures are different.

APPENDIX H.

H. **EMPIRICAL RESEARCH ON INFORMAL PAYMENTS IN HUNGARY**

H.1. **Summary table**

Table H1 provides a detailed description of empirical research in Hungary between 1969 and 2001. The table does not list empirical research, which is associated with the generation of official statistics, such as the household budget surveys (HBS) of the Hungarian Central Statistical Office (HCSO).

There are three recent research studies, which partially addressed the topic of informal payments and are not listed either (the Ministry of Health’s national health survey in 2001 and a survey which targeted exclusively the Roma population in 2002-2003, and a survey of the Social Research Informatics Centre (TÁRKI), in 2002-2003), but these did not generate differing new evidence, which would change the conclusions of chapter 4 on existing empirical evidence.

Table H1. Empirical research on informal payment in Hungary

#	Research (Source)	Unit of analysis /observation	(Study) Population	Sample size (Response rate)	Sampling (frame)	Method of data collection**	Main topics Remarks
1	OTKI* 1969 (June) [77]	Household /?	District VI, VII & VIII of Budapest	459 /?(?)	random (?)	survey, face to face interview (-)	<ul style="list-style-type: none"> • Expectation & satisfaction with GP service; private sector utilisation; out of pocket payments (amounts, motivation) • qualitative responses incl.
2	DOTÉ* 1970? [82]	individual medical doctor	medical doctors of the university	130 /300(43.3%)	? (?)	survey, postal questionnaire (-)	<ul style="list-style-type: none"> • Satisfaction with the present position; salary & workload; advantages of university posts; reward system; gratitude payments & gifts; moonlighting; position in the social hierarchy • qualitative responses incl.
3	OTKI* 1970 [226]	individual patient	OTKI patients (aged over 14)	718 /?(2 rounds, 1st round only 50%)	all patients with at least 3-day stays in a 3-week period	survey, face to face interview (-)	<ul style="list-style-type: none"> • Hospital admission (why?, how?); satisfaction with the hospital; relationship with the doctor, nurse, other patients; satisfaction with hospital infrastructure
4	OTKI* 1972-73 [78; 227]	individual patient	all hospital patients aged 16-75 between 1/7/1972-31/3/1973, excluding less than 5-day stays	4,396 /9,898 (44.4%)	random (medical records)	survey, postal questionnaire (+)	<ul style="list-style-type: none"> • Previous hospitalisations; experiences of latest hospital stay (information; staff; hotel service; leisure time; visits); informal payment (money // gift; doctors // nurses // cleaners), motivation; continuation of care after discharge
5	County-Hospital-Eger-1973 (first half) [80]	individual patient	Eger County Hospital patients (excluding psychiatry, neonatology)	1,046 /4,300(24.3%)	all patients between 30/4/1973 – 1/3/1973	survey, self-completion questionnaire with on site collection (/)	<ul style="list-style-type: none"> • Patient satisfaction; informal payment • Ill-designed study & questionnaire • Qualitative responses incl.
6	DOTÉ* 1973 [190]	individual	Debrecen factory of Hungarian Roller-Bearing Works	461 /500(92.2%)	stratified random (?)	survey, self-completion questionnaire with on site collection (/)	<ul style="list-style-type: none"> • Patient satisfaction; private sector utilisation; informal payments (motivation)
7	ELTE* 1973 [198]	individual medical doctor	medical doctors in Hungary	? /?(?)	? (?)	survey, face to face interview (/)	<ul style="list-style-type: none"> • Including opinion on gratitude payment
8	OTKI* 1981 [81, preliminary report; 228]	individual patient	Hospital (national); Polyclinic, Occupational and Primary care (Budapest VIII & Nógrád County)	1,606 /3,000(53.6%)	mixed (previous study; utilisation lists of a day)	survey, postal questionnaires (-)	<ul style="list-style-type: none"> • Patient satisfaction; private sector utilisation; Informal payments (motivation); Need for change • 4 questionnaires

#	Research (Source)	Unit of analysis /observation	(Study) Population	Sample size (Response rate)	Sampling (frame)	Method of data collection**	Main topics Remarks
9	OTKI*, KSH 1984 [201]	individual /household	general population of Hungary	20,103 /20,204(99.5%) (in 7,398 households)	random (KSH ELAR sample)	survey, face to face interview (+)	• Health status & health care utilisation; sickness benefit; satisfaction with health workers and services; informal payment
10	TK* 1985 [79]	individual	general population of Hungary	1,000 /?(?)	random panel	survey, face to face interview (+); and content analysis of popular media	• Radio listening and TV watching habits; health services (problems, satisfaction); informal payment (motivation, willingness to pay, etc.)
11	MTA SZKI* 1983 [199]	individual patient	patients with arteriosclerosis obliterans (patients discharged from two hospitals in Hungary)	41+58=99	? (medical records)	in-depth interviews	• Access to services, patients' routes in the system
12	Ádám [50; 49; 67]	period documents	early medieval period - 1984	-	-	historical analysis	• The history of informal payments
13	SZEKI* 1983-84 [83]	individual medical doctors	hospital doctors of Budapest	100 (?) /?(?)	? (?)	in-depth interviews	• Salaries, wages; informal payment; income from private practice
14	GKI* 1986 (December) [200]	Household /?	private households of Hungary	13,500 /16,000(84.4%)	random (KSH ELAR M sample)	survey, face to face interview (+)	• household expenditures on tip, under-the-counter payment, unregistered work (tax evasion), gratitude payment
15	MTA SZKI* 1988 [71; 217]	primipara	lived in 6 settlements in Pest county, expected first child in 1988	294/? (?)	?	survey, face to face interview (-) and follow up interviews	• health status, preparation for delivery, psychological status, health services utilization (including private practice, informal payments)
16	TÁRKI* 1992 (May) [229]	individual medical doctor	practising physicians of Hungary	1,000 /?(?)	stratified random (?)	survey, face to face interview (+)	• General condition in the workplace, salaries; knowledge about health care reform; opinion about health policy actors, health care reform and social insurance
17	SZGTI* 1992 [223]	household	private households of Hungary	2,000 /?(?)		survey, face to face interview (+)	• Hidden economy; household expenditures on tip, gratitude payment, unregistered purchases (purchase w/o invoice)
18	SZGTI* 1994 [75]	Household /?	private households of Hungary	5,000 /?(?)	random ?	survey, face to face interview (+)	• Health status & medicine consumption; extra expenses of illness; association between life-style and health status; expenses on prevention; knowledge and opinion on social insurance

#	Research (Source)	Unit of analysis /observation	(Study) Population	Sample size (Response rate)	Sampling (frame)	Method of data collection**	Main topics Remarks
19	SOTE* 1995 [224]	individual	general population (aged over 16)	12,640 /?(?)	random (KSH)	survey, face to face interview (+)	• Market research of health insurance; health status and health care utilisation; quality of life; life style; attitudes (lack of hostility); social support; life objectives; coping; work competence; mass media
20	TÁRKI* 1996 [216]	individuals	practising GPs of Hungary general population ambulatory patients (PC) paramedical workers (PC) local government officials specialists (dermatology, ENT, internal medicine)	1,351 /?(?) 1,500 /?(?) 1,008 /?(?) 1,367 /?(?) 47 /?(?) 272 /296(91.9%)	stratified random (NHIFA, Central Registering and Election Office)	survey, face to face interview (+) semi-structured interview	• Basic features of family doctor system; praxis income and financial management; status and position of nurses and health visitors; free choice of doctor; opinions on primary care; patient movement in the system
21	KSH-1997 [225]	households	private households of Hungary	2,682 /2,879(93.2%)	stratified random (KSH ELAR)	survey, face to face interview (+)	• Hidden economy; household expenditures on tip, gratitude payment, unregistered purchases (purchase w/o invoice)
22	TÁRKI* 1998 (1999) [214]	individuals	general population of Hungary practising physicians (internal medicine, surgery, paediatrics, psychiatry & neurology)	1,392 /?(?) 1,006 /?(?)	stratified random ?	survey, face to face interviews	• informal payments: attitudes, extent, "prices", overall magnitude, socio-economic determinants, timing, enforcement by providers, connections, referral

Notes: *DOTE = Debreceni Orvostudományi Egyetem, Marxista-Leninista Intézet [Debrecen University of Medicine, Department of Marxism-Leninism]; ELTE = Eötvös Loránd Tudományegyetem Bölcsészettudományi Kar, Szociológia Intézet [Eötvös Loránd University of Sciences, Faculty of Humanities, Department of Sociology]; GKI = Gazdaságkutató Intézet [Economic Research Institute]; KSH = Központi Statisztikai Hivatal [Hungarian Central Statistical Office]; MTA SZKI = Magyar Tudományos Akadémia Szociológiai Kutató Intézet [Hungarian Academy of Sciences, Sociological Research Institute]; OTKI = Orvostovábbképző Intézet, Egészségügyi Szervezési Tanszék [Institute of Medical Doctors' Further Training, Department of Health Care Organisation]; SOTE = Semmelweis Orvostudományi Egyetem, Magatartástudományi Intézet [Semmelweis University of Medicine, Institute of Behavioural Sciences]; SZGTI = Szakszervezetek Gazdaság- és Társadalomkutató Intézete [Economy and Social Research Institute of Trade Unions]; SZEKI = Szakszervezetek Elméleti Kutató Intézete [Theoretical Research Institute of Trade Unions]; TÁRKI = Társadalomkutatási és Informatikai Egyesülés, Social Research Informatics Center (SRIC); TK = Tömegkommunikációs Kutatóközpont [Mass-media Research Institute]

** + = questionnaire available; - = questionnaire not available; / = partly included in the publication

APPENDIX I. MOTIVATION & THE PRIVATE SECTOR

I. PRIVATE SECTOR INFORMAL PAYMENTS

As discussed previously, the 'donation' explanation for informal payment is based on the assumption that by giving money patients would like to express their gratitude for having been cured. If this is so, then there is no reason to believe that they would not do the same in the 'pure' private sector, even though they already have to pay out-of-pocket for the services they obtain. Consequently if informal payments existed in the private sector this would support the 'donation' hypothesis. In this case study we explore this phenomenon first by establishing whether informal payments do exist in the private sector, and second by trying to gain insight into the motivation for such payments using in-depth interviews with doctors and patients.

I.1. Summary of the case

Although we did not expect the phenomenon to occur frequently, and indeed this was one of the reasons why we chose a private hospital (the only one in Hungary) rather than a polyclinic, we did not preclude the possibility that it would exist.

Altogether, six patients were identified and interviewed.

The physician sample was selected in cooperation with the hospital's management. Eleven physicians were selected and agreed to participate, but it was only possible to conduct 9 interviews.

The framework for interviewing patients was the same as that used with patients in the public sector in the research reported in the main thesis. However, the interviews with physicians were different in two respects. First, as most of them had decided to give up their public sector employment we wanted to explore this decision to gain insight into the 'exit' issue. Further, asking about the employment history of respondents offered the opportunity to contrast their work experiences in the public and the private sector. Second, as we have pointed out before, we put greater emphasis on exploring actual cases of informal payments.

The TELKI private hospital is a new building approximately 10 kilometres from the outskirts of Budapest that began to operate in the autumn of 1998. The hospital has 100 beds in two-bedded rooms and provides a limited number of in- and outpatient services, in the main specialties. The conditions in the hospital are excellent. The rooms are equipped with colour TV, telephone, en-suite bathroom; the second bed in each room is for relatives to sleep in. Of course the prices are also distinctive and it is not surprising that about half of the patients who choose TELKI are foreigners.

The hospital employs doctors either on a part-time or a full-time basis, but full-time doctors, the so-called 'staff-doctors' are given one day off each week to work in the public sector. The TELKI private hospital operates a strict policy of not accepting informal payments, with the exception of in-kind gifts, such as flowers, chocolate, and alcoholic drinks. Violation by doctors is punishable by dismissal.

The interviews with doctors in the TELKI hospital revealed that informal payments do exist in the private sector – a finding confirmed by our Kecskemét study – although the frequency seems to be much lower than in the public sector. All but one of the doctors, have encountered a few patients who attempted to pay in addition to the official

fees although it was not possible to tell the exact proportion patients who did so, because no records are kept and data on patient turnover are considered commercially confidential. Furthermore, the extent to which interviewees were willing to discuss this issue varied, suggesting a degree of sensitivity. However it was clear that attempts to pay are much less frequent in TELKI than in the public sector.

Some interviewees also compared their experiences in TELKI with those in their public sector practice, noting an apparent difference in the frequency of attempts, at least concerning 'gifts' of money. In contrast, one of the doctors stated that there was no difference in non-monetary gifts (which are allowed in TELKI).

What is behind private sector informal payments? While we have assumed that the existence of this phenomenon supports the 'donation' explanation for informal payments, interviews with doctors and patients reveal that this is a more complex issue, where gratitude is but one factor in what is a far from straightforward process.

In the analysis of the 'coercion' factor, we have argued that confusion about entitlements can contribute to the development of a view that certain services are considered 'extra' and so must be paid for. On the one hand, doctors in TELKI emphasized that patients have adequate information about the prices and the method of settling the bill, and consequently they are aware that they do not have to pay the doctor separately. On the other hand, the interviews revealed that one way in which people attempt to pay is not by the patient offering money directly, such as putting an envelope on the table, hiding it in a gift, or flashing a wad of notes, all of which do happen, but rather that they enquire about, whether they have to pay. This seeming discrepancy may indicate that patients project their public sector experiences into the private sector. The entire public system is influenced by this contradiction between rhetoric and reality so it is possible that some of patients remain uncertain about whether the introduction they are given to the payment process is just lip-service and the harsh reality is that doctors do expect additional money, or whether it does reflect confusion about how to settle the bill. While they double-check, their reactions suggest that the attempts to pay have nothing to do with gratitude.

This explanation is further supported by evidence that previous experiences with Hungarian health services do matter. Doctors noted that foreigners rarely attempt to pay, except those who have been living in Hungary for a longer period of time.

According to some doctors, the ability of patients to pay also matters. As one of the doctors noted, the patients who choose TELKI are much better off than the staff, and can easily afford a payment, while another pointed out that some patients were the middle class, especially those who had bad experiences in the public sector and while they could afford TELKI, the total sum did matter. In this context informal payment could be considered unnecessary extra expenditure. On the other hand there could be a motivation to give, even in these circumstances, reflecting previous experiences with the services provided by public providers and the severity of the illness.

Maybe these are cases that are the closest to the gratitude payment concept, as understood by the 'donation' hypothesis, suggesting that 'genuine' gratitude can be a motive for informal payments in the private sector.

Nevertheless, this assessment is based exclusively on the perspectives of doctors. Therefore, to get further, albeit very limited, insight into this issue, we draw on the interviews with the two patients identified as making private sector informal payments.

We found four patients who stated that they had made private sector informal payments: one from TELKI and three from the Kecskemét survey, although of the latter, only one was a true case of private sector informal payments. Thus, only two patients could be interviewed but both extended the scope of the alternative explanation of 'non-coercive' reasons for giving: (1) the 'custom' aspect of motivation and the 'reflex' approach, and (2) the 'gratitude' aspect of motivation with the 'I am grateful because I have received unsatisfactory care so far' approach. These cases have also provided insight into how the blurred boundaries between the public and private sector can influence informal payments.

A key conclusion that could be drawn from these two interviews is that the motivation for such payments is complex and multifaceted, supporting the contention that survey questionnaires inevitably oversimplify the reality. This further reinforces of our findings that surveys are not appropriate tools to capture motivation and their results can be misleading. Overall it seems that most examples of what are a relatively few cases of private sector informal payments fit better with a 'coercive' interpretative framework, but the motivation of patients needs to be explored in a more systematic manner in future research. The case study method is by no means appropriate to draw general conclusions, especially with so few cases involved, and we have to take into account the limitations of human memory and perceptions, especially if one has to form an opinion on the motives of others.

APPENDIX J.

J. PUBLICATIONS, CONFERENCE PRESENTATIONS AND WORKING DOCUMENTS RELATED TO THE THESIS

J.1. Publications and conference presentations

J.1.1. THE DESCRIPTION AND EVALUATION OF THE HUNGARIAN HEALTH CARE SYSTEM AND HEALTH CARE REFORMS

- Gaál, P, Rékassy, B, Healy, J (1999): Health Care Systems in Transition: Hungary. Copenhagen: European Observatory on Health Care Systems
- Gaál, P (2002): Chapter 19: Hungary in Fried, BJ, Gaydos, LM (ed.): World Health Systems: Challenges and Perspectives. Chicago, Illinois: Health Administration Press, Washington, D.C: AUPHA Press, pp.329-342
- Gaál, P, Evetovits, T (2002): The Purchasing Function in the Hungarian Health Care System. Case study prepared for the European Observatory on Health Care Systems' purchasing study

Forthcoming:

- Gaál, P: Health Care Systems in Transition: Hungary. Brussels: European Observatory on Health Care Systems.

J.1.2. HEALTH POLICY ANALYSIS

- Gaál, P (2000): Értékek és nézőpontok az egészségügyben [Values and views in health sector reform] Keynote speech, Symposium on Health Economics and Values in Health Care, 22/09/2000. Budapest: Health Services Management Training Centre, Semmelweis University, Astrazeneca Kft.
- Gaál, P (2001): Egészségpolitika: Az egészségügyi rendszer menedzsmentjének alapismeretei [Health Policy: The Foundations of the Management of Health Care Systems] Budapest: Health Services Management Training Centre, Semmelweis University
- Evetovits, T, Gaál, P (2002): A félreérthetőség káros az egészségre [Ambiguity is Bad for Your Health]. *Egészségügyi Menedzsment* 4 (5): 28-33.
- Evetovits T, Gaál P (2003): Mennyire hatékony a költség-hatékony? Hogyan lett egy elemzési módszer nevéből önálló hatékonyság fogalom [How efficient is a cost-effective therapy? How has a technique for economic evaluation become an individual efficiency concept] *Egészségügyi Menedzsment* 5 (2): 74-81.

J.1.3. INFORMAL PAYMENTS

- Gaál, P (1997): Under-the-table Payment and Health Care Reforms in Hungary
- Gaál, P (1998): The Myth of Gratitude: Informal Payments and Health Care Reforms in Hungary
- Gaál, P (1999): Informal Payment in the Hungarian Health Services. Case studies prepared for the Observatory funding study. Mossialos, E, Dixon, A, Figueras, J,

Kutzin, J (2001): Funding Health Care: Options in Europe. European Observatory on Health Care Systems; comments

Accepted for publication:

- Gaál, P, McKee, M: Fee-for-service or donation: Theories of informal payments for health care (Social Science and Medicine)
- Gaál, P, McKee, M: Informal payments for health care and the theory of inexit (International Journal of Health Planning and Management)

Submitted for publication:

- Gaál, P, Belli, P, McKee, M, Szócska, M: Images of informal payments for health care in countries in transition (Health policy, Politics and Law)
- Gaál, P, Evetovits, T, McKee, M: Informal payments for health care: Evidence from Hungary (Health Policy)

J.2. List of working documents

J.2.1. BACKGROUND MATERIAL FOR BACKGROUND INFORMATION

- Description of the Hungarian health care system
- History of informal payment in Hungary

J.2.2. LITERATURE REVIEW

- Theoretical and general literature
- Empirical literature including major findings and the translation of questionnaires
- International experiences

J.2.3. METHODOLOGICAL EXPERIENCES

J.2.4. IN-DEPTH INTERVIEWS IN THE PREPARATORY PHASE

- 2 researchers and 1 physician

J.2.5. PRACTICAL INFORMATION FOR THE RESEARCH

- sampling frames
- survey companies
- useful addresses and contact persons

J.2.6. EMPIRICAL MATERIALS PROCESSED

- transcripts of in-depth interviews (TELKI, Kecskemét, Budapest)
- survey database
- excerpt from official statistics (HCSO, household budget surveys)

J.2.7. EMPIRICAL MATERIALS NOT PROCESSED

- database of health care providers
- transcripts of interviews (Misszió case study)
- documents related to 'exit' and 'voice'